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An action research study on the adoption of a Lean Management System in a healthcare organization attempting to transform its culture

Par

JOANNE ROBERTS

Thèse présentée à l'École de gestion

comme exigence partielle

du doctorat en administration (DBA)

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Cette thèse a été évaluée par un jury composé des personnes suivantes :

Pre Madeleine Audet	Présidente du jury
Pr Mario Roy	Directeur de recherche
Pre Ann Langley	Examinatrice externe
Pre Viviane Gascon	Représentant de l'UQTR
Marco Thibault	Représentant du milieu de pratique

SUMMARY

This dissertation focuses on the adoption of an integrated performance management system (inspired by a Lean philosophy) in a Quebec healthcare institution.

Several institutions in the field of healthcare have adopted Lean principles with the objective of improving the quality of care and services. Unfortunately, an emphasis on the adoption of tools and techniques has limited its potential for improvement since one of the main pillars of a lean philosophy, respect for people, has been lost in translation. The belief that people are the greatest asset of an organization, and that investment in their development is essential, is central to the dynamic learning ability that is the heart of a Lean philosophy (Holweg, 2007).

Studies of organizational learning from a cultural perspective highlight that learning is the result of the interactions between people and organizational elements, and this learning is embodied in the artifacts of culture. Organizational culture is, therefore, a social, dynamic and cyclical phenomenon that is constantly redefining itself. In this study, an organization is seen as a culture (contrary to the view that an organization 'has' a culture), whereby an organization is defined as a loosely structured and incompletely shared system of symbols and meanings that emerges through dynamic interaction[1]. This interaction leads either to a reinforcement or to a change in symbols and meanings.

The objective of this study is to illustrate from a cultural perspective, how a healthcare organization implements an integrated lean management system. The research strategy is a longitudinal study, carried out as action research. It is situated in a postmodern pragmatist paradigm (rooted in the philosophical tradition of Chia (2003)) where the researcher participates directly with members of the organization, introducing reflexive practices that help guide action and generate knowledge. Two iterative cycles were completed, during which research participants supported the organization in changing 'the way things are done', with the goal of improving the safety and delivery of care through efficient processes, judicious use of resources, dedication of employees to their practice, and accessibility of care and services. In other words, to refocus actions on the 'core business' (clinical operations).

Qualitative data was collected over a three-year period. The data consisted of the researcher's observation notes, sixty-two semi-structured interviews, and institutional documents. The data collected was analyzed in several stages; a descriptive account of the process was generated first; an analysis of the lean transformation over the period of the study was then conducted; and finally, the implementation process was analyzed from a cultural perspective. The descriptive narrative account of the change process begins with the CHUS in 2014 introducing their integrated performance management system (SPCHUS) and ends with the

[1] This definition is adapted from an anonymous reviewer (1987) cited in Martin, 2002, p.58.

CIUSSS of Estrie-CHUS (created as a result of the reform adopted in February and implemented in April 2015) and the adoption of their system SGIP. Included in the descriptive narrative are the key learnings of the research participants following each action research cycle, and the adjustments made to the introduction of the performance management system for the next steps in implementation. Of particular note in the learnings and the subsequent adjustments was the behavioral nature of the changes, with little (if any) questioning of the notably classic beliefs of management manifested in individual actions and interactions. A lean philosophy of management inherently relies on very different beliefs, and the discrepancy between the beliefs of the current and desired system should be made explicit in order for changes in the underlying mindset to occur. As Toussaint and Berry (2013) so eloquently state "before we can change we need to understand why we act as we do" (p. 11).

The analysis of the lean transformation that occurred over both action research cycles highlighted how the instrumentalism of the implementation, the bureaucratic nature of the organization, and the various understandings coexisting in the organization concerning Lean contributed to the lack of learning in the organization. The present research reinforced previous findings that organizational learning is fundamental for achieving a philosophy driven level of transformation, and that moving from a tool-driven to a system-driven level of transformation is extremely difficult in public healthcare (Mackenzie and Hall, 2015). In addition, the in-depth study of the implementation of a management system rooted in a lean philosophy answers a suggestion for research in this key area that is under investigated in the current literature (D'Andreamatteo, Ianni, Lega and Sargiacomo, 2015).

The final level of analysis attempts to partially fill the gap in the scientific literature of analyzing lean implementations from a cultural perspective. This study analyzes the change process using Hatch's (1993) dynamic model of organizational culture with very specific examples allowing the researcher to illustrate that the adoption of an integrated management system, inspired by a Lean philosophy, requires a cultural change. The key to cultural change is the change in meanings that arises through interaction, and as this study has illustrated, this occurs through organizational learning. This requires an approach to implementation that demonstrates a desire to learn. It also requires a change of perspective concerning the role of the leader in culture change as the orchestrater of change, which dominates the literature. Instead, a leader's role becomes one of managing meaning, of inviting input from others, asking probing questions, encouraging multiple points of view and providing opportunities for discussion and reflection.

Thus, while leaders are making enormous efforts to re-structure and re-conceptualize public healthcare institutions, this study illustrates the need to pay attention to meanings that are generated through interaction, as cultural evolution emerges precisely from these interactions (Houle and Roberts, 2016).

RÉSUMÉ

Cette thèse porte sur l'adoption d'un système intégré de gestion de la performance (inspiré de la philosophie de gestion Lean) dans un établissement de soins de santé québécois.

Dans le but d'améliorer la qualité de leurs soins et services, plusieurs institutions dans le domaine des soins de santé ont adhéré aux principes de gestion Lean. Malheureusement, l'emphase mise sur l'adoption d'outils et de techniques a fini par en limiter le potentiel d'amélioration. Par conséquent, le respect de l'individu – un des points fondamentaux de la philosophie de gestion Lean, semble avoir été oublié dans le processus. Pourtant, la conviction voulant que les individus soient l'atout principal d'une organisation et qu'investir dans leur développement soit essentiel, a un rôle central dans la capacité d'apprentissage dynamique au cœur de la philosophie de gestion Lean (Holweg, 2007).

D'un point de vue culturel, les études sur l'apprentissage organisationnel font entrevoir l'apprentissage comme le résultat d'interactions entre des gens et des éléments organisationnels; cet apprentissage est le fondement d'une culture. À cet égard, la culture organisationnelle est un phénomène social, dynamique et cyclique qui ne cesse de se redéfinir. Selon cette étude, l'organisation « n'a » pas une culture mais en « est » une. Cette culture dévoile, à travers les interactions individuelles, un système de symboles et de significations peu structuré et mal partagé. Une interaction pourrait mener soit à un renforcement, soit à un changement de symboles et de significations.

L'objectif de la présente étude est d'illustrer d'un point de vue culturel, comment une organisation de soins de santé met en œuvre un système de gestion Lean. La stratégie de recherche est longitudinale et réalisée dans le cadre d'une recherche-action. Elle a été menée selon un paradigme pragmatiste postmoderne (ancré dans la tradition philosophique de Chia (2003)), où le chercheur participe directement, de concert avec les membres de l'organisation, à l'étude. Le chercheur introduit des pratiques réflexives, lesquelles servent tant à guider les actions qu'à insuffler de nouvelles connaissances. Deux cycles itératifs ont été complétés : les participants à l'étude ont soutenu l'organisation en changeant « la façon de faire les choses ». L'objectif était d'améliorer la sûreté et l'administration des soins grâce à des processus efficaces, à une utilisation judicieuse des ressources, au dévouement des employés envers leurs pratiques et à l'accessibilité des soins et services. En d'autres termes, il s'agissait de recentrer l'action sur l'activité principale : les opérations cliniques.

Des données qualitatives ont été recueillies sur une période de trois ans. Elles sont issues des notes et observations de la chercheuse, de soixante-deux entrevues semi-structurées ainsi que de documents institutionnels secondaires. Les données recueillies ont été analysées à différents stades : une description du processus a d'abord été établie, suivie d'une analyse de la transformation Lean pendant la période de l'étude. Pour conclure, le processus de changement a été analysé dans une perspective culturelle. Le compte rendu narratif du processus de changement commence avec le CHUS en 2014, lors de l'implantation de son système intégré de gestion de la performance (SPCHUS) et se termine avec le CIUSSS du Estrie-CHUS (issu de la réforme adoptée en février et implantée en avril 2015) et l'adoption de son système SGIP. Le compte rendu narratif comprend les principaux apprentissages des participants à la suite de chacun des cycles de recherche-action, ainsi qu'une description des ajustements apportés à l'introduction du système de gestion de la performance pour les prochaines étapes de son implantation. Au cours de l'apprentissage et des ajustements ultérieurs, il a été noté que le changement au niveau comportemental ne s'effectuait que peu ou pas. Les interactions observées ont démontré que les pratiques « classiques » n'étaient pas remises en question et perduraient. Or, la philosophie de gestion Lean reposant essentiellement sur une approche très différente, l'écart entre le système souhaité et le système tel qu'il est appliqué en réalité devrait être davantage souligné, afin de provoquer des changements concrets au niveau des mentalités.

L'analyse de la transformation Lean sur les deux cycles de recherche-action a révélé que le manque d'apprentissage organisationnel à l'intérieur de l'organisation a été influencé par la mise en place, la nature bureaucratique et les différentes compréhensions de Lean coexistant au sein de l'organisation. La présente recherche corrobore les conclusions précédentes selon lesquelles l'apprentissage organisationnel est fondamental pour atteindre une réelle transformation de la philosophie existante et qu'il est extrêmement difficile dans les soins de santé publics de passer d'un mode-outil à un mode-système (Mackenzie and Hall, 2015). Enfin, l'étude approfondie de la mise en place d'un système de gestion inspiré de la philosophie de gestion Lean répond à une suggestion de recherche dans ce domaine clé étudié actuellement (D'Andreamatteo, Ianni, Lega and Sargiacomo, 2015).

Le dernier niveau d'analyse tente de combler partiellement le vide dans la littérature scientifique en se penchant sur l'analyse des implantations de Lean d'un point de vue culturel. La présente étude analyse le processus de changement selon le modèle dynamique de culture organisationnelle de Hatch (1993). Le chercheur, exemples très spécifiques à l'appui, illustre que l'adoption d'un système intégré de gestion, inspiré de la philosophie Lean, requiert un changement culturel. La clé du changement culturel se situe dans les interactions. Cela nécessite non seulement une approche qui démontre un désir d'apprendre, mais un changement de vision du rôle de leader et de sa manière de gérer, il n'est plus un simple orchestrateur de changement tel que défini dans la littérature sur le sujet. Désormais, le rôle du leader consiste à gérer l'évolution, à inviter

les autres à poser des questions et à donner leur opinion, à encourager les différents points de vue ainsi qu'à créer des occasions de discussions et de réflexions.

Ainsi, pendant que certains leaders font des efforts importants pour restructurer et redéfinir les institutions de soins de santé publics, cette étude démontre la nécessité de prêter attention à l'importance des interactions, car l'évolution culturelle découle précisément de ces interactions (Houle and Roberts, 2016).

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GLOSSARY

5s	Workplace organization method described by 5 Japanese words: seiri (sort), seiton (straighten), seiso (shine), seiketsu (standardize), and shitsuke (sustain)
A3	A structured problem-solving approach, introduced by Toyota, and based on the scientific method. A3 comes from the size of the paper used (ISO A3)
AAPA	Approche adaptée à des personnes âgées (Approach adapted to ederly people)
ACQP	Amélioration quotidienne de la qualité et performance (Daily continuous improvement of quality and performance or DCI)
AGESSS	Association des gestionnaires des établissements de santé et services sociaux (Association of Managers of Health and Social Services Establishments)
CCID	Comité de coordination inter-direction (Inter-directional Coordination Committee)
CÉTO	Centre d'études en transformation des organisations (Centre for Studies in Organizational Transformation)
CHUS	Centre hospitalier universitaire de Sherbrooke
CISSS	Centre intégré de santé et services sociaux
CIUSSS	Centre intégré universitaire de santé et services sociaux
CSSS	Centre de santé et services sociaux
DAEPO	Direction adjoint évaluation, performance et optimisation (Adjunct Department of Organizational Performance, Evaluation and Optimization)
DAR	Direction administrative de recherche (Administrative Research Department)
DCI	Daily continuous improvement
DGA	Direction générale adjointe (Assistant General Direction)

DI-TSA-DP	Déficience intellectuelle, trouble de spectre de l'autisme, déficience physique (Intellectual disability, Disorders in the spectrum of autism, physical impairment)
DISC	Direction interdisciplinaire des services cliniques (Interdisciplinary Department of Clinical Services)
DQPEP	Direction de la qualité, de la planification, et de l'évaluation de la performance (Department of Quality, Planning, and Performance Evaluation)
DQÉPÉ	Direction de la qualité, de l'évaluation de la performance et de l'éthique (Department of Quality, Performance Evaluation and Ethics)
DRFL	Direction des ressources financières et logistiques (Department of Finance and Logistics)
DRHCAJ	Direction des ressources humaines, communications et affaires juridiques (Department of Human Resources, Communication and Legal Affairs)
DRHE	Direction des ressources humaines et de l'enseignement (Departement of Human Resources and Teaching)
DSP	Direction des services professionnels (Department of Professional Services)
EMC	Executive Management Committee (bureau de direction)
Gemba	A japanese term meaning the real place. In the Toyota Production System, gemba refers to the place where value is created.
GPS	A project at the CHUS with the objective of improving the working conditions of intermediate managers while simultaneously improving organizational performance. GPS stands for Gestionnaires (G) – Performance (P) – Sens (S).
IOM	Insititute of Medecine, an independent, nonprofit organization that works outside of the US government to provide unbiased and authoritative information on healthcare.
IRISS	Chaire interdisciplinaire de recherche et d'intervention dans les services de santé

Kaizen	The practice of continuous improvement
LEADS	The model of transformational leadership chosen by the CHUS. The model was developed by the Canadian College of Health Leaders and represents the key skills, abilities and knowledge required to lead at all levels of a healthcare organization
LDMS	Lean Daily Management system
LMS	Lean Management System
MHSS	Ministry of Health and Social Services (Ministère de santé et des services sociaux (MSSS))
Muda	A Japanese term for waste.
Mura	A Japanese term for unevenness or variability.
Muri	A Japanese term for unreasonableness or overburden.
Obeya	Obeya is a Japanese word that translates to "big room" in English. It has often been interpreted as the bridge of a ship, a war room, a command center or a brain. An Obeya is a collaborative environment where the critical indicators of the organization's performance are displayed, reviewed, discussed and acted upon by a multidisciplinary team.
PDCA	Problem solving cycle of Plan-Do-Check-Adjust
PDG	Président et directeur général (President and CEO)
PDGA	Président et directeur général adjoint (Assistant President and CEO)
PODC	Plan, Organize, Direct and Control
PORs	Pratiques organisationnelles requises (Required Organizational Practices)
RÉST	Réseau des équipes de soutien à la transformation (Network of Transformation Support Teams)
SMT	Senior Management Team. At the CIUSSS de l'Estrie – CHUS this includes the EMC and the Directors.

SGIP	Système de gestion intégrée de performance (Integrated performance management system)
SME	Subject Matter Expert
SPCHUS	Système de performance du CHUS (performance management system at the CHUS)
Standardization	Standardization, or standardized work is a lean tool. The current best practice of a process is documented and forms the baseline for continuous improvement. Once the process is improved it is once again standardized so that improvements will not be lost over time.
TSO	Transformation Support Office (Bureau de soutien à la transformation (BST))
TMPE	Taux de mortalité potentiellement évitable (Potentially Avoidable Mortality Rate)
VSM	Value Stream Mapping. A lean management method for analyzing the current state of a process and designing a future state for the series of events that take a product or service from its beginning through to delivering value to the customer.
Visual Controls	A lean management technique for communicating information through the use of visual signals rather than text. The visual controls allow for quick communication on the status of a process, pointing quickly to problem areas requiring attention.

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The doctoral process can only be described as a journey. It is a long arduous path, with many ups and downs. A researcher rotates through periods of doubt, confidence, creativity, solitude, despair, and joy in their attempt to add something interesting to the already substantial existing body of knowledge. Navigating through this tumultuous terrain is never a solo journey. There are several people to whom I am deeply grateful for the support and assistance provided throughout the process.

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This research would not have been possible without the active involvement of members of the participating organizations. The co-researchers at both the CHUS and the CIUSSS de l'Estrie – CHUS were extremely generous with their time; the

discussion and reflection with various members of the organization led to results that contribute to the advance of scientific knowledge at the crossroads of lean transformations and organizational culture. A very special thank you to Mathieu Desmarais with whom I worked closely over the entire period of the research; it was a real pleasure to work with you. I would also like to take this opportunity to acknowledge the research grants from the MHSS and the CIUSSS de l'Estrie CHUS to support the doctoral research.

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INTRODUCTION

As with healthcare systems elsewhere in Canada, the United States and Europe, the healthcare system in Quebec is highly solicited and under a great deal of pressure. Government officials and managers must improve performance of the institutions within the healthcare system, reducing waiting times and costs, while improving the quality of care and services to patients. Several publications, including the Institute of Medicine's (IOM) report *The Quality Chasm: a New Health System for the 21st century,* have documented the severe gap between the healthcare that exists and the healthcare that people should expect to receive. The report highlights six fundamental dimensions of healthcare requiring improvement: safety, effectiveness, patient centeredness, timeliness, efficiency and equity (Berwick, 2002). The response in 2005 of Canada and Quebec to this important issue was structural changes to the organization of the delivery of healthcare through the creation of Health and Social Service Centers, Family Medicine Groups, Regional Health Authorities, and Alternate Care Networks (Levine, 2005). Notwithstanding the structural reform, the province continues to struggle with problems of inefficacy, accessibility and quality despite close to 50% of provincial spending on healthcare ($32 billion)[2]. Prior to the adoption of Bill 10 (an act to modify the organization and governance of the health and social services network, through the abolishment the regional agencies), there was some evidence of a shift in focus from the structure of healthcare delivery to the guiding principles behind its delivery. As in several other countries, the healthcare sector in Quebec began adopting lean principles from the manufacturing sector to improve safety, quality, effectiveness and efficiency.

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[2] Source : http://www.budget.finances.gouv.qc.ca/budget/2013-2014/en/documents/budgetplan.pdf, consulted February 15th, 2014, http://www.budget.finances.gouv.qc.ca/budget/2014-2015/fr/documents/Planbudgetaire.pdf, consulted October 25th, 2016, http://www.budget.finances.gouv.qc.ca/budget/2015-2016/fr/documents/PlanEconBref_2015-2016.pdf, consulted October 25th, 2016.

"Lean" has its roots in the Toyota Production System (TPS) developed by Taichi Ohno. While Ohno is credited with inventing a new production system, the development of TPS was in fact a continuous learning cycle that spanned several decades (Holweg, 2007). Given that one of the key concepts of TPS is the elimination of waste in all aspects of a process, TPS came to be known as "lean" in North America with the publication of the book *The Machine That Changed the World* by Womack, Jones and Roos (1990). North American companies, looking for more modern manufacturing methods to reduce costs and improve efficiency, have adopted the lean management practices associated with waste elimination, ignoring the second fundamental concept of TPS "to make full use of the workers' capabilities […] in short treat the workers as human beings and with consideration" (Sugimori, Kusunoki, Cho and Uchikawa, 1977, p. 554). Organizations that manage per TPS share the overarching belief that people are the most important corporate asset and that investment in their skills and knowledge is essential (Spear, 2005). Furthermore, the dynamic learning capability that is created through continuous improvement is the heart of TPS (Holweg, 2007).

Most healthcare establishments implementing lean management are guided by the lean principles documented in the book *Lean Thinking* (Womack and Jones, 2003). The customer is defined as the patient/user and is clearly placed at the centre of the sites' preoccupations; however, this is not easily translated into practices. The majority of institutions are still organized around specific functions and not around the pathway of care of the patient. Other important challenges are noted in the implementation (training) and maintenance (management systems to ensure that the changes are permanent; required long-term commitment of the senior management team) of lean principles are compounded by the required change in the role of managers; important changes to the work processes of employees; and the (sometimes difficult to get) required implication of doctors in determining better methods (Janrick and Vermette, 2013).

Implementation of lean varies greatly, with only a handful of examples of excellence approaching the level of Toyota (Burgess and Radnor, 2013; Liker and Hoseus, 2008). Radnor and Walley (2008) indicate that the majority of healthcare institutions focus on short-term and localized approaches, implementing lean tools to respond to pressures for improved productivity and efficiency. The complexity and the siloed mechanistic/bureaucratic structure of healthcare organizations, however, limit the potential of localized initiatives.

While several authors question, given the barriers, if it is possible to transfer managerial practices from the private sector to the public sector (Radnor, Holweg and Waring, 2012; Timmons, Coffry and Vezyrides, 2014; Waring and Bishop, 2010) many others indicate that it is possible; however, successful implementation requires that lean be viewed as a philosophy and not a short-term strategy for cost savings (Bhasin, 2012; Bhasin and Burcher, 2006). It needs to permeate the culture and the thinking of the organization; it needs to become a way of delivering care. Changing organizational culture is believed to be a facilitator to lean implementations (Bhasin, 2012); however, transforming culture, is a complex task. Compounding this, public healthcare organizations are very difficult to change (Carlström and Ekman, 2012; Rusaw, 2007).

In 2009, the CHUS committed to a "profound transformation"[3], and detailed this transformation in their 2012-2015 strategic plan. The vision of a better performing, more inspiring, and human organization reflects the desired change. The principal element of transformation was the integration of a management system (embodying a lean philosophy) focused on the operational performance of patient trajectories and the alignment of the organizational structure around the patient pathways of care rather than in functional silos, further reinforcing the patient-focused care project of 2000 to 2006 that involved the reorganization of clinical services around eleven patient

[3] Source : *Projet d'implantation de l'approche Lean Healthcare dans des établissements du réseau de la santé et des service sociaux*. Appel de candidature, Phase II, Version 0.5, 2013-05-23. Unpublished internal document.

programs. The design of this management system SPCHUS (système de performance du CHUS)[4], embodied the changes the organization wished to implement to face the increasing complexity of the environment, and to address several barriers to transformation, many of them similar to the barriers to lean healthcare noted in the scientific literature. The organization describes the change as a cultural transformation, touching all aspects of the organization.

The objective of my research is to illustrate, from a cultural perspective, how a healthcare organization implements an integrated lean management system. The first formal contact with the research participants was in January of 2014, at the first meeting of the project team responsible for the development and planning of the deployment strategy for the integrated performance management system at the CHUS. In February 2015, Bill 10 was adopted into law, and the healthcare network embarked on major structural reform. As a result, the CHUS, along with 13 other health establishments and the regional health agency, integrated into the CIUSSS de l'Estrie—CHUS on April 1st, 2015. Within the newly formed organization the integrated performance management system, under the label SGIP (système de gestion intégré de performance)[5] continued to evolve. Over the period of the study, the various organizational members from the CHUS and from the CIUSSS de l'Estrie—CHUS involved in the development and deployment of the integrated management system were an invaluable source of data.

This dissertation illustrates the cyclical and complex nature of the process of change resulting from the implementation of an integrated management system. It recounts the process whereby the researcher moves between action and critical reflection, converging towards a better understanding of what is happening (Dick, 2002; French, 2009). The nature of this action research study relates not only a spiraling change in the participants' and the researcher's understanding concerning the

[4] Loose translation: Performance management system for the CHUS.
[5] Loose translation: Integrated performance management system.

implementation of an integrated management system over the course of the study, but also highlights the learning and development of the researcher concerning her practice of research.

The research is presented in five chapters. The first three chapters combined form the conceptual framework of the study constituting my argument as to why the topic I have chosen to study matters, and why the means proposed to study it are "appropriate and rigorous" (Ravitch and Riggan, 2012, p. xiii). Chapter One grounds the study in a very real managerial problem facing the CHUS (which is equally problematic in the new organization of the CIUSSS de l'Estrie — CHUS), along with providing context on the public healthcare system in Quebec and the importance of resolving the managerial problem for the improvement of healthcare delivery. Chapter Two, the theoretical framework, provides an overview of the theoretical constructs from the scientific literature that appear to be the most pertinent to the resolution of the managerial problem under study, their relationships and how they informed both the development of my research question, as well as the choice of a methodological approach. Chapter 3 introduces the research methodology, methods, data analysis techniques, and quality, validity and ethical considerations and concludes with a visual summary of the conceptual framework. The results and analysis of the study are presented in Chapter 4 and illustrate the learning/reflection/action components of the action research cycles, summarizing the key elements that influenced the introduction of an integrated management system. The analysis then turns to a cultural analysis of the adoption of an integrated management system. Chapter 5 discusses the theoretical and practical implications of the research and provides suggestions for future research. The dissertation concludes by highlighting how a lean philosophy has the potential to "transform the culture of an organization into one that embraces change and learning" (Tsasis and Bruce-Barrett, 2008, p. 197) providing an opportunity for comprehensive change in the healthcare sector.

It is important to note the bilingual nature of this dissertation. All interviews, meetings, observations and documentation (the raw data) for this research are in French, while the dissertation is written in English (given that English is the researcher's first language). For this reason, all citations included in the paper will be in their original language in the body of the text. This is important so as not to distort the participant's intention through inadequate translation (Esin, Fathi and Squire, 2014). The translations of all citations have been included as endnotes (numbered with Roman numerals to distinguish between the footnotes) in Appendix A, in order to improve the readability of the document.

CHAPTER ONE
MANAGERIAL PROBLEM

To fully understand the managerial problem leading to the development and deployment of the program SPCHUS, it is important to understand the macro context of the healthcare system in Quebec, the organizational context of the CHUS, and the origins of the program SPCHUS. These elements are presented in the following sections, and the chapter will conclude with a concise description of the managerial problem facing the CHUS. The description of the context of the CHUS and the background of the program SPCHUS is based on over 250 hours of participant observation in meetings concerning the program SPCHUS, interviews with seven members of the organization in various hierarchal positions, secondary review of internal documentation, and field notes from my residency at the CHUS from January 2014 to August 2015.

1. CONTEXT

1.1. Macro Context: Healthcare in Quebec

In Canada, healthcare is managed provincially. The Canada Medical Care Act of 1966 institutionalized the public healthcare system as we know it today. The system is publicly funded but privately run, and provides universal coverage that is free (Irvine, Ferguson and Cackett, 2002). The principle of the system is based on payment of healthcare professionals for services rendered by the government. The federal government transfers funding to the provinces who have the constitutional responsibility of planning, financing and evaluating the quality of care, of negotiating salaries of healthcare professionals and of negotiating physician fees for services rendered (Irvine *et al.*, 2002). At the introduction of Medicare, the federal government shared healthcare costs with the provinces in a ratio of 50-50.

Concerned about rising medical costs, the federal government abandoned this cost-sharing arrangement in 1977, leaving the provinces to absorb a greater share if

healthcare costs grew more rapidly than the provincial economy. The 1984 Health Care Act reinforced the nation's commitment to universal healthcare. The Act, however, in addition to banning the practice of extra billing by physicians introduced the following specific standards to be met by the provinces to receive federal funding: comprehensiveness, portability, public administration and universality (Irvine *et al*., 2002). Still struggling with rising medical costs, and an accumulation of debt following decades of deficit spending the federal government introduced in 1998 the Health and Social Transfer Fund, bundling federal payments for education, healthcare, social assistance and other social programs into one transfer fund, and leaving the provinces to determine the priorities for spending (Iglehart, 2000).

The federal share of healthcare costs has moved a long way from the 50-50 cost sharing as was the case in 1977; in 2002, federal payments accounted for little more than 20% of the total cost (Irvine *et al*., 2002). Rising costs and diminished federal support placed enormous pressure on healthcare organizations to control expenditures, led to lengthened waiting lists, and limited investment in new technology and medical equipment. In 2000, concerned with the deterioration of primary care, the Primary Health Care Transition Fund was created to accelerate primary healthcare reform. Further funding provided in 2003 was aimed at supporting reform that would, among other things, improve access to primary care services, improve the quality and appropriateness of care and support the implementation and use of electronic records (Hutchison, Levesque, Strumpf and Coyle, 2011). The goals of the primary healthcare reform echo the six improvement goals of the 2001 IOM report: safety, effectiveness, patient centeredness, timeliness, efficiency and equity (Berwick, 2005). The emphasis, however, of the Canadian reform was on timeliness, effectiveness and cost control (rather than on efficiency) (Hutchison *et al*., 2011).

In 2003, major structural reform was instigated in Quebec. The reorganization included the creation of Health and Social Service Centers, Family Medicine Groups, Regional Health Authorities, and Alternate Care Networks (Levine, 2005). The reform

was driven by concerns around the need to control cost of healthcare given an aging population, the desire to move to more emphasis on prevention than treatment in healthcare, and the need to improve coordination of services for increasingly complex and co-morbid illnesses (Cloutier, Denis, Langley and Lamothe, 2015). Reforms were also initiated in many of the Canadian provinces; however, they were most aggressively pursued in Quebec, Ontario and Alberta (Hutchison *et al*., 2011). In the review of healthcare reform across Canada, Hutchison *et al*. (2011) note that the performance of the structural changes in Quebec, particularly the creation of Family Medicine Groups, is superior to that of other healthcare models. There are, nevertheless, many studies that indicate that structural reform alone will not improve healthcare performance (Looi *et al*., 2016) and identify several elements that limit the potential of structural changes in improving overall healthcare delivery. Foremost, an improvement in healthcare requires an understanding of the current state and the implementation of key measures to track performance improvements. Many provinces are moving in the direction of establishing performance indicators at the local, regional and provincial levels, but the progress is slow given the reticence of many to provide this information to the general public. Secondly, the engagement of physicians is difficult to obtain in any reform that they believe may threaten their professional autonomy. Innovations in healthcare delivery will only be successful with the presence and support of the medical profession at the policy table. Thirdly, the current payment method is not tied to the results or quality of services rendered. While some countries have demonstrated an interest in moving to this type of payment method, none have actually made a change (Simoens and Guiffrida, 2004).

Structural reforms have brought some improvements; nevertheless, even with half of the provincial budget on healthcare, there are still issues of efficacy, accessibility and quality. In 2008, with the appointment of Yves Bolduc as Health Minister, the Toyota methodology was introduced to improve healthcare. Mr. Bolduc credited with successfully using the methodology for the first time in the operating

theatre at the Val-d'Or Hospital[6], institutionalized it under the banner of Lean Healthcare in 2011. The starting point of lean thinking is Value as defined by the customer. Next comes an understanding of the Value Stream, which includes identifying all the specific activities required to bring the product or service to the customer and challenging all the non-value adding activities. Once the value stream steps have been identified, it is necessary to make the remaining value creating steps Flow. Standardization of processes keeps the processes running smoothly freeing up time for problem solving and innovation. The fourth step, Pull, allows the organization to provide only what the customer needs exactly at the time it is needed. The final and crucial aspect of the lean principles is Perfection, continuously striving for an ideal (Womack and Jones, 2003). Several tools and techniques that support these lean principles, such as kaizen, 5s, visual controls, standardization, value stream mapping and daily meetings have been implemented in many establishments within the healthcare sector[7].

In November 2011, the MHSS launched the first phase of the Lean Healthcare program, investing $12 million in the introduction of Lean Healthcare at three hospitals, and at the same time developing principles adapted to the healthcare system in Quebec. The principles of Lean Healthcare as defined by the Ministry are[8]:

A. Focus on customer value;
B. Engagement of workers and doctors in problem identification, solution generation and selection;
C. Commitment of key actors in managing transformational projects (union representatives, department heads, doctors);
D. Continuous improvement through the elimination of non-value add activities and increased accountability of all organizational members;
E. Delegation of authority to decision makers closest to the process;
F. Long-term vision and philosophy to ensure sustainability.

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[6]Source: http://ici.radio-canada.ca/regions/abitibi/2010/07/05/002-CSSS_Amos_methode_Toyota.shtml, consulted March 2, 2015.
[7] A description of these tools may be found in the Glossary.
[8] Adapted from http://www.msss.gouv.qc.ca/reseau/lean-sante/

These principles are similar to Lean Healthcare implemented in other institutions in the US and Canada (e.g. Thedacare, St. Boniface, Virginia Mason Medical Centre), who have seen notable improvements in the safety and quality of services, operating costs, and collaboration and satisfaction of workers as a result of following these principles.

In the fall of 2013, the MHSS launched the second phase of lean healthcare, investing an additional $12 million to support another sixteen establishments in their deployment of lean. While the first phase was focused on the implementation of lean projects at three sites, the second phase was focused on the deployment of management systems that would enable a lean culture. The CHUS was one of the sixteen institutions accepted as part of Phase II.

With the election of the Liberal Government in 2014, several austerity measures were announced in proposed Bills. Among them, Bill 10, passed into law on Feb 7, 2015, proposed the merger of health and social services into a single integrated entity with the intention of simplifying and improving the fluidity of the path of care for the patient[9]. The government also indicated that the reform was intended to reduce the existing infrastructure and bureaucracy, by reducing the previous three levels of governance to two. The existing eighteen regional health authorities, created in the reform of 2005, were abolished, and the 182 public healthcare establishments (which included the CSSSs) were reduced to 34 integrated centres of health and social services (CISSS). The CHUS, one of nine integrated university centres, was the only one that retained the designation as a university health centre; the new entity became the CIUSSS de l'Estrie — CHUS. The minister of health and social services, Gaétan Barette indicated that the structural changes would not only improve and simplify the trajectories of patient care, but also improve the flow of patient information, reduce the

[9] The information concerning Bill 10 is based on the presentation prepared by the Ministry, available on their website http://www.msss.gouv.qc.ca/documentation/salle-de-presse/medias/Presentation-info-techniquePL10.pdf , and accessed on December 11th, 2014.

governance costs of the system, and create more direct accountability for the quality of services offered. The Bill did not mention if the approach of lean healthcare would continue to be supported.

1.2. Organizational Context: The CHUS

The CHUS was the fourth-largest hospital in Quebec offering standard healthcare services to the local population of Sherbrooke, Haut-Saint-François, Val-Saint-François and Coaticook. The CHUS also offered specialized and ultra-specialized services, including natal and neonatal, obstetric and gynecological, psychiatric and specialized medicine. Since the creation of the Réseau universitaire intégrés de santé (RUIS)[10], the establishment also offered ultra-specialized services in cardiology, neurosurgery, oncology, and neonatology to the population of the Centre-de-Quebec and some areas of Montérégie. In total, the CHUS provided services for a population of approximately 1 million. With over 6000 employees, and 690 doctors and pharmacists, the CHUS was the second largest employer in the Eastern Townships. Healthcare services were administered over two sites: Fleurimont and Hôtel Dieu. The mission of the CHUS also included a strong research component, supported by 216 researchers and 665 students.[11]

The CHUS was created from the fusion of four acute care hospitals St. Vincent de Paul, Hôtel Dieu, CHUS and the Sherbrooke Hospital in 1995 under the name of the CUSE (Centre universitaire de santé de l'Estrie). The name was changed back to the original designation CHUS in 2000. The logistics of the fusion, and the integration of services took approximately six years to fully complete. The first strategic plan of the new entity was completed in 2001. The plan was the outcome of a top down process, necessary at that point in time to move past the turmoil of the fusion. The strategic

[10] The English translation for RUIS is a university integrated health network. These networks promote collaboration and complementarity, and fulfill the combined mission of care, teaching and research that is incumbent upon the health institutions and the universities with which they are affiliated.
[11] source: rapport annuel 2013-2014 consulted November 3rd, 2014 on the website of the CHUS: http://www.chus.qc.ca/medias-publications-chus/rapports-annuels-et-statistiques/rapport-annuel-2013-2014/

plan of 2006-2009, on the other hand, was created through consultation with employee groups, doctors, community groups, and board members. In an effort to ensure that all stakeholders felt that their voice was heard, the strategic plan resembled a 'to do' list including a large majority of employee suggestions. The plan included 18 orientations and 86 objectives.

During the period 2001 to 2009, several initiatives were particularly influential to the orientation of the most recent 2012-2015 strategic plan, which the CHUS viewed as a pivotal event in their history. The timeline of the important events leading up to the strategic plan, and the subsequent creation of the program SPCHUS, may be found in Table 1. The elements, identified during my residency, are those that were key factors in the development of the program SPCHUS and by no means attempt to trace a historical portrait of the CHUS.

Table 1
Timeline of Key Events Leading to the Development of SPCHUS

	2001-2006	2006-2009	2009	2009-2012	2012	2012-2013	2013
Structural Changes			The board of directors requests that the CHUS establish an integrated management model that synthesizes the strategic initiatives of the establishment		2012-2015 Strategic Plan introduced.		SPCHUS accepted by the MHSS for financing in Phase II of Lean Healthcare Implementaiton in Quebec
Patient-Focused Care Programs	Pilot Program in 2001 followed by the implementation of 11 such programs	Growing discontent of clinic-administrative managers with excessive workload, lack of management support, underutilization of employee potential, siloed management, reactive versus proactive culture		Beginnings of reflection on organizing around patient trajectories			
Nursing services reorganization	Concern for quality of healthcare delivery and patient safety during a shortage of nursing staff leads to the addition of auxiliary nurses and orderlies and patient services specialists to support chief nurses						
Key Projets							
Kaizen	Pilot Kaizen in 2005.	Several kaizens conducted with outside consultants. Internal resource hired in 2008 and a kaizen team created		Members of the senior management team visit St. Boniface and Thedacare		Senior management gemba visits introduced. Agrement Canada audit demonstrates the necessity to concentrate on day-to-day operations.	
GPS		Workgroup formed to address growing discontent. Beginning of GPS		GPS accepted by the MHSS for financing.		GPS project ends and the program SPCHUS is developed.	
Balanced Scorecard	No clear key indicators of performance – multiple indicators followed by the senior management team			The project team, facilitated by Alain Rondeau chose the balanced scorecard as the performance model of the CHUS		Executive 'war room' for tracking performance created.	

Two organizational structural changes are of particular importance to understanding the development of SPCHUS. In 2001, the CHUS piloted a model of Patient Focused Care. The principle of the model, a popular example of re-engineering in US healthcare establishments, was to provide a single point of service to patients with a similar pathology. The goal was to improve the quality of healthcare services while reducing costs. The change involved the creation of a care team under a clinical-administrative manager and a medical manager. Following the pilot, the hospital continued rolling out the patient-focused care model to ten other clinical areas between 2001 and 2006.

Also, in 2001, the CHUS embarked on an organizational change in response to a shortage of nurses. Given the lack of nursing staff in several services the organizational structure was changed to include an auxiliary nurse and an orderly/patient care specialist creating a care team. The structural change was also accompanied by a redefinition of roles with the intention of ensuring that nurses, in short supply, were using their time for tasks that only they could perform by law. While increasing the number of resources within a service, the change also increased the managerial responsibility for the chief nurse. As with the implementation of the patient care teams, the organizational response to alleviate the nursing shortage continued through and beyond 2006.

As these changes were being rolled out throughout the hospital, there was rising dissatisfaction manifested by the clinical-administrative managers. Complaints included an excessive workload, a lack of management support, and a lack of recognition. Also noted was the centralization of authority, the underutilization of employee potential, a lack of clearly defined priorities, a long decision-making process, siloed management and a reactive versus proactive culture[12].

[12] Source : unpublished internal document of the CHUS entitled « Rôles et responsabilités des gestionnaires. Rapport des travaux des projets pilotes » dated June 12th, 2006.

Two large-scale initiatives were introduced based on these two difficulties: 1) kaizen projects, and 2) the organization-wide GPS project (Gestionnaires-Performance-Sens). Under the direction of the Finance and Technical Services Director, recently hired from a manufacturing facility, the CHUS began experimenting with kaizen events (rapid improvement workshops) to improve clinical and administrative processes. A few kaizen events were conducted with outside consultants to the satisfaction of the CHUS. Between 2008 and 2015, over 50 events were conducted. The results of the events, albeit interesting, were often the result of the initiative of individual departments and were not tied to organizational strategic imperatives. Other difficulties noted with the kaizen initiatives included a lack of participation by medical professionals, and unintended consequences to departments either upstream or downstream of the initiatives. Some confusion within the organization was created when the term 'Lean' began to be used in the healthcare sector as many members of the organization believed Kaizen and Lean to be synonymous. The distinction between the tools and techniques of Lean, such as Kaizen, and Lean as a management philosophy had not yet been made (Landry, Chaussé and Paris, 2014).

In parallel to the adoption of the balanced scorecard, the GPS project was also in development. The objective of the project was to improve organizational performance and, hence, improve work conditions for intermediate-level managers. The project included three key dimensions: 1) G (gestionnaires)—protect the time that managers have in proximity with their team members acting in an advisory and supportive manner; 2) P (performance)—maintain a dynamic equilibrium between the elements identified in the balanced scorecard adopted by the management team; and 3) S (sens)—focus and alignment of strategic objectives, and the development of leadership competencies for mid-level managers. Work conditions of mid-level managers was an issue that was widespread in the healthcare sector, hence, the MHSS initiated a program that funded establishments that introduced projects focused on improving work conditions and developing/defining the role and responsibilities

of intermediate managers. In 2010, the project GPS was accepted for financing by the MHSS.

Along with the development of the Kaizen initiatives and the introduction of the GPS project, the CHUS was also working on numerous other projects aligned with the 86 objectives of the 2006–2009 strategic plan. In 2009, the Board of Directors of the hospital, struggling to find the common thread that linked all the elements together, formally requested that the senior management team develop/adopt a management model that would integrate the various projects under coherent objectives aligned with the strategic issues of the organization. A project team was formed to determine the most appropriate model that would integrate the organization's strategic preoccupations and mobilize the employees and doctors around organizational priorities, increase their participation in decision-making, and clarify the common thread linking the numerous projects and initiatives of the organization[13]. The result of the project team's work, with the support of Alain Rondeau, professor and director of the Centre for Studies in Organizational Transformation (CÉTO) at the HEC Montreal was the adoption of a Balanced Scorecard, which the CHUS decided to adopt as their performance model and which the Board approved in 2010. The performance scorecard included four elements or levers to improved performance: process efficiency; judicious utilization of resources; employee engagement; and quality and accessibility of care and services. For the CHUS, performance was defined as a dynamic equilibrium between the four elements. Per the presentation by the project team to the Board, the model would support decision-making and would allow the translation of the strategic preoccupations into objectives aligned with each of the spheres of performance.

The creation of the 2012–2015 strategic plan provides a concise overview of the progress of the CHUS since the previous 2006–2009 strategic plan and reflects the

[13] The objectives of the project team are documented in an unpublished internal document of the CHUS entitled "Démarche intégrative: comparaison des modèles de gestion" by Jean-Guillaume Marquis dated March 16th, 2010

complexity of the environment and the challenges the CHUS faced in delivering high quality healthcare efficiently. The mission, values and vision were modified, and the plan demonstrates a simplified and more integrated approach to meeting the strategic challenges. As stated in the 2012–2013 annual report these are defined as follows[14]:

> Mission :
> L'équipe du CHUS, en misant sur l'enseignement et la recherche et en partenariat avec le milieu, prodigue des soins et services de grande qualité centrés sur les besoins de santé de ses populations.
>
> Values :
> Le respect – Au CHUS, nous entretenons avec les autres des rapports fondés sur l'égard et la considération. Ce respect se traduit chaque jour dans nos paroles, nos comportements et nos actions.
> L'écoute – Au CHUS, nous portons attention aux gens qui nous entourent. Nous sommes disponibles, empathiques et ouverts aux autres, car écouter est la base même de toute relation humaine.
> L'esprit d'équipe – Au CHUS, nous unissons nos connaissances pour atteindre notre objectif commun, soit offrir les meilleurs soins et services possibles. Nous avons besoin de cet enrichissement mutuel.
> Le professionnalisme – Au CHUS, nous accomplissons notre travail avec compétence, intégrité, transparence et rigueur.
> La créativité – Au CHUS, nous sommes ouverts à explorer de nouvelles avenues pour relever les défis quotidiens et continuer de répondre aux besoins des patients.
>
> Vision :
> Vers un CHUS plus performant et inspirant, à dimension humaine[i].

The 2012–2015 strategic plan represents the culmination of the desire to align the efforts of the organization on improving the performance of the care and services provided to patients. It reflects a shift in concern from improving processes per the needs of the organization to focusing on the needs of the patient and their families. Finally, it reflects a desire to move from project-based improvement efforts to daily continuous improvement, focused on improving the day-to-day delivery of care. The necessity for this shift was underscored by the results of the audit of Accreditation

[14] As mentioned in the introduction, translations of all citations in French may be found in Appendix A, each citation includes an endnote in roman numerals to facilitate the location of each translation of citations in the text.

Canada in the fall of 2013. Certification was maintained, nevertheless, the cited non-conformities indicated that the hospital was not meeting all the standards set out by the independent organization in terms of quality, safety and efficiency.

The management team looking for a way to improve focus on daily operations visited one of the most notable hospitals that had implemented a lean management system, Thedacare. Thedacare is a Wisconsin-based integrated health system. It consists of two major hospitals, 20 primary care offices, a network of specialists, nursing homes, assisted-living facilities and hospice care, inpatient and outpatient psychiatric care, physical therapy, and home health services. Overall, ThedaCare facilities get more than 20,000 hospital admissions every year and the organization is the largest employer in northeast Wisconsin with about 5,500 people on staff (Toussaint and Gerard, 2010). In 2002, Thedacare embarked on a lean transformation to meet an urgent need to improve quality and efficiency while reducing costs. Toussaint, Billi and Graban, (2017) summarize their definition of lean as follows:

> Lean thinking […] is about providing the right resources to provide the right care, at the right time, in the right place, with the right safety and quality (p. 1).

One important part of the lean system that the organization implemented was the identification of nine critical indicators of performance (patient safety, health and safety of employees, preventable mortality rate, 30-day readmission rate, customer satisfaction, employee engagement, health assessment, operating margins and productivity). It was felt that improvements in these indicators would facilitate the achievement of "measurably better value for patients and other stakeholders" (Toussaint and Berry, 2013, p. 75). The organization created its own business performance, rooted in Lean Thinking, identifying the following three principles that would drive the system and methodologies of improvement: focus on patients and design care around them; identify value for the patient and eliminate anything that does not add value; and minimize time to treatment and throughout its course (Toussaint and Gerard, 2010).

The results of a lean implementation at their facilities are impressive, and many organizations, including the CHUS were interested in understanding the reasons behind their success. When Thedacare began the implementation of these lean principles, the mortality rate for coronary bypass surgery was 4% (12 deaths a year); over a period of seven years, through initiatives underscoring their principles, this was reduced to nearly zero. In addition, the average time spent receiving care decreased from 6.3 to 4.9 days, and the cost of intervention dropped 22%. They continue to refine their management system and learn from their efforts, all with the objective of enhancing patient experience, improving medical outcomes and lowering costs, and have seen improvements in the total cost of patient care, improved patient satisfaction, and the number of medical errors.

This visit by senior organizational members of the CHUS, in addition to a previous visit to another lean hospital, St. Boniface, demonstrated that it was possible to do things differently in healthcare. Following the visits, the management team experimented with several tools related to a lean management system such as gemba visits, A3s, visual controls and daily caucuses.

The program SPCHUS[15] is the result of the desire of the senior management team to change the way things were being done and introduce a management system, inspired by a lean philosophy, adapted to their organizational context.

1.3. SPCHUS

The program SPCHUS is the natural evolution of the project GPS, and the desire for a profound transformation of the organizational culture described in the 2012–2015 strategic plan. It represents a management system that once fully

[15] SPCHUS becomes SGIP (systéme de gestion intégrée de performance) at the CIUSSS de l'Estrie – CHUS. The program SGIP is also rooted in the desire to 'change the way things are done' in healthcare. Both programs are equivalent to a Lean Management system as defined in the scientific literature, and which is described in more detail in Chapter 2.

implemented is hoped will change the 'way things are done' at the CHUS. The necessity for the implementation of SPCHUS is evident in the following statement by a director at the CHUS[16]:

> Parce que les dernières années certaines données qualité nous questionnaient énormément. Exemple les taux de mortalité à 30 jours où les réhospitalisations, etc. Donc on avait une grande inquiétude dans certains secteurs. Il y avait aussi un autre élément qui était la détérioration au niveau du climat de travail puis notre capacité à retenir nos professionnels. Nous, pour certains titres professionnels, dont les infirmières, notre taux de rétention à 2 ans était il y en a 60% qui partait là. Il était énorme. Il y avait 4 sur 10 qui partaient. Il était à 60% le taux de rétention. Donc, ça, c'est énorme parce que vous comprenez qu'on investit beaucoup dans de la nouvelle… donc tout ça on s'est mis à se questionner sur le rôle des gestionnaires par rapport au soutien à leur équipe. Comment ils les accompagnent ? Comment ils les soutiennent ? Comment ils les cadrent ? [ii]

> On s'est rendu compte aussi, en cours de route, dans le GPS qu'on était noyé par une multitude de projets dans l'organisation qui, dans le fond, ne finissaient jamais. Donc, les gens se dispersaient. Nos gestionnaires étaient dispersés dans plusieurs projets. Ils n'étaient pas présents sur les unités de soins ou dans leur secteur non-clinique. Puis les projets n'avançaient pas. Donc, c'est beaucoup dans cet esprit-là pour dire comment peut-on développer un système de performance qui puisse atteindre certains éléments que je vous mentionne-là[iii].

SPCHUS is inspired by the management system of Bombardier Recreational Products. The CHUS indicates that they did not want to adopt a model such as Planetree, but instead wanted a system that was unique to their organization. The finality of the transformation desired with the implementation of SPCHUS is described by the organization as follows:

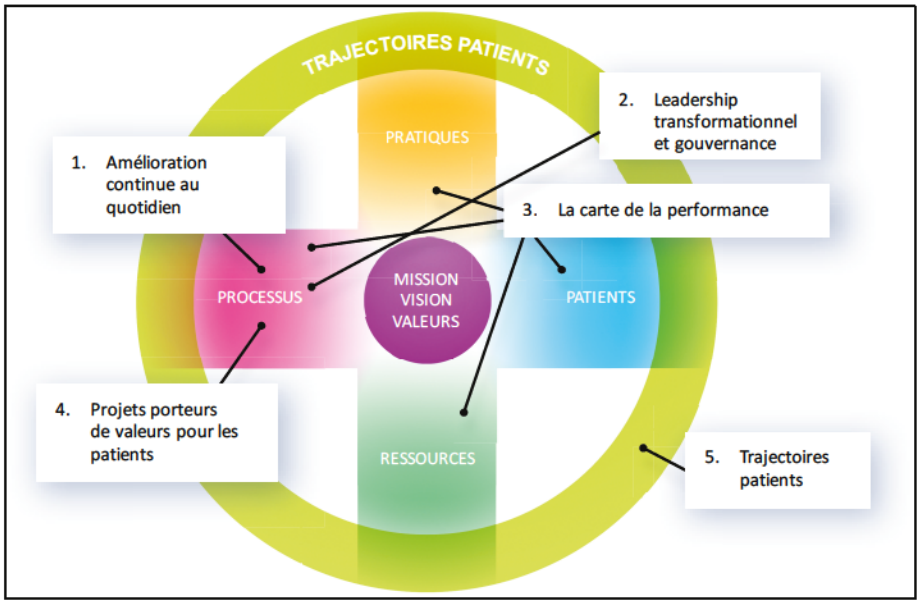
> De façon transversale, au travers toutes les directions, améliorer les trajectoires patients par les processus efficients, des ressources utilisées judicieusement, des personnes engagées envers leurs pratiques et des soins et services accessibles et de qualité pour les patients. Cette amélioration se

[16] All of the citations used have been reviewed to remove hesitations, repetitions, incomplete phrases and slang, while maintaining the essential message of the participant. Given that all citations are provided in the text in their original language, the loose translations to English will not be provided as footnotes, as this would severely affect the readability of this dissertation, but instead are provided as endnotes in Appendix 10.

traduira par une plus grande mobilisation du personnel, des gestionnaires et des médecins envers les patients.[17]

The organization committed to achieving this vision through a profound transformation that would have repercussions at all levels of the organization: the mission, the organizational structure, the management philosophy and practices, in addition to its culture. The five dimensions of SPCHUS, which would be the drivers of this transformation, include: the deployment of a daily continuous improvement system, development of transformational leadership skills, introduction of a balanced scorecard to measure performance and facilitate decision-making, organization of work processes around patient trajectories, and implementation of organizational projects focused on improving patient value.

Figure 1
Five Elements of SPCHUS



Source: Internal presentation for organizational members

[17] From the internal unedited document titled "Programme PGM100 : Déploiement du système de performance du Centre hospitalier universitaire de Sherbrooke". Loose translation: Transversely across all departments, improve patient trajectories through efficient processes, judicious use of resources, people dedicated to their practice, and accessible care and services. This improvement will translate into a greater focus of employees, managers and doctors towards the patient.

The heart of the program SPCHUS is the mission, vision and values of the organization, representing a focus on providing quality care and services that meet the needs of patients and the population. Under the proposed program model, the performance of the care and services offered would be evaluated based on the four elements of the balanced scorecard. Care and services would be organized around patient trajectories, and all employees, medical professionals, patients and their families would participate in daily continuous improvement of the performance of these trajectories. Projects, representing less than 20% of managers' time according to the philosophy of SPCHUS, would be prioritized based on the value they have for the patient. And managers would be supported in their efforts to improve the performance of patient trajectories through coaching in the LEADS[18] model of transformational leadership.

The details of SPCHUS (identified as program PGM100) may be found in Appendix B. For each of the five elements several key orientations are identified, and embedded in these key orientations, objectives are enumerated along with specific goals. In summary, there were 5 elements, 13 orientations, and 42 objectives. The program SPCHUS was developed principally by the assistant general manager, responsible not only for the program development but also for the proposal of the governing program structure. As the program champion, this person worked in collaboration with several senior members of the organization to develop the program framework. Interestingly, the kaizen team was not involved in the development but became involved in later stages of deployment.

Based on the details of the program, the CHUS was selected in October 2013 as one of the 16 additional healthcare establishments to receive funding for Phase II of the MHSS's Lean Healthcare initiative. In the application for Phase II, the CHUS

[18] The LEADS framework is a leadership model for the Canadian healthcare sector representing the key skills, abilities and knowledge required to lead at all levels of an organization. The framework was developed by the Canadian College of Health Leaders.

included a request for additional financing to support a doctoral research project concerning the cultural transformation associated with the deployment of the management system SPCHUS. I was accepted as the doctoral research candidate based on my history in lean management, my certification as a lean/six sigma engineer and my experience in the deployment of a lean management system while Plant Manager for the Sherbrooke Facility of Baxter Corporation[19]. My involvement with the program SPCHUS began at the first meeting of the Development and Planning team on January 16, 2014.

2. MANAGERIAL PROBLEM

The quality, cost, patient centeredness, efficiency and accessibility of healthcare remains problematic in Quebec. Significant efforts have been, and continue to be made, by the provincial government to improve care and services, through structural changes, and through the adoption of lean principles. The CHUS has made significant progress in recognizing the need to invest much more effort in the day-to-day delivery of care, rather than tackling operational issues through projects such as those to improve the financial situation (such as a project team dedicated to reducing overtime) or conformity (such as the special task force created to resolve the non-conformities of the Accreditation Canada audit). The 2012–2015 strategic plan reflects the effort to align and focus the organization on strategic preoccupations, and the development of the program SPCHUS indicates the strong desire to improve the performance of patient trajectories through the implementation of a performance management system which includes daily continuous improvement and development of the appropriate leadership capabilities at all levels of the organization. To do this all

[19] Baxter Corporation, as a subsidiary of Baxter International Inc., manufactures and markets products that save and sustain the lives of people with hemophilia, immune disorders, infectious diseases, kidney disease, trauma and other chronic and acute medical conditions. It is a global, diversified healthcare company that applies a unique combination of expertise in medical devices, pharmaceuticals and biotechnology to create products that advance patient care worldwide. These products are used by hospitals, kidney dialysis centres, nursing homes, rehabilitation centres, doctors' offices, clinical and medical research laboratories, and by patients at home under physician supervision. The Sherbrooke facility assembled intravenous administration sets for the Canadian market for 23 years until its closure in 2011.

members of the institution, employees and doctors, must work in collaboration towards common goals. Managers must work in partnership with employees, encouraging autonomous decision-making, acting as coaches to facilitate improvement, developing the potential of their employees' capabilities for problem solving, and encouraging the inclusion of the patient's voice in decision-making.

The problem facing the CHUS, given the existing strongly anchored organizational practices (project management versus operational management, strong division of labour [silos], and command-and-control style leadership[20]), is how to implement SPCHUS as an integrated management system in order to obtain a clearly desired change in organizational culture ultimately leading to lasting improvements in the delivery of care at the CHUS.[21]

[20] All of these characteristics were identified by the organization as elements that were targeted for change through SPCHUS

[21] This is the managerial problem as presented in my research proposition. Towards the end of the first action research cycle, Bill 10 was adopted into law, throwing the entire healthcare system into a state of turmoil with the reorganization of the health and social services. The newly created entity CIUSSS de l'Estrie – CHUS describe the necessity for the adoption of integrated performance management system, rooted in a lean philosophy, in similar terms to the managerial problem described for the CHUS. The urgency is, however, amplified, as the challenge in complex environment in turbulent times is to maintain and improve the performance of care and delivery of services by concentrating on the daily operations within the healthcare establishment.

CHAPTER TWO
THEORETICAL FRAMEWORK

The theoretical framework detailed in this chapter represents how I believe the various constructs are interrelated and how this interrelatedness provides insight into the managerial problem as defined in the previous chapter. The development of the theoretical framework was influenced by my personal professional history, a critical review of the relevant literature pertaining to each of the constructs, and the managerial problem identified. This chapter explores these and will finish with a synthesis of the theoretical framework and the specific research question of this study. It is important to note that additional constructs were explored during the research. These constructs and their relevance to the emerging learning in the research cycles will be discussed in the narrative in Chapter 4.

1. THEORETICAL CONSTRUCTS

Given that the managerial problem concerns the implementation of a lean management system in the healthcare sector, the construction of the theoretical framework began with a review of the key elements of such a system, and how lean is viewed in the scientific literature. As the construct of lean was developed in the manufacturing sector, an understanding of how lean management practices were translated to the healthcare sector, and the barriers to this transfer were next explored. This literature led to investigation of the construct of organizational culture, as most of the literature documenting the success and failures of lean implementations points to organizational culture as either a barrier to or a facilitator of implementation. If success (or failure) depends on having the appropriate organizational culture, it followed that an understanding of how culture changes would be beneficial to my study. Organizational learning is often referenced in the literature on culture change, hence, this was the final construct scrutinized. In the following sections, each of these constructs will be presented, and woven together to reveal how the various constructs informed and supported the development of my specific research question.

1.1. Lean Management

Based on my professional history I was curious to investigate how lean was represented in the scientific literature. There is a surprising amount of research on the cause of the failures related to the implementation of lean manufacturing, and on the negative impacts of lean practices on employees. Hasle, Bojessen, Jensen and Bramming (2012) performed a review of the literature on lean to better understand its relationship with the working environment, and its effect on employee health, job satisfaction and commitment. Their review attempted to settle the ongoing debate on whether lean is mean or is a healthy and productive work concept. The results suggest that both negative and positive outcomes are present, however, the negatives appear to dominate. These include lower job autonomy, higher demands, faster work pace, increased workload and augmented work intensity. In terms of effects on health, the authors report several studies linking lean to anxiety, stress and lower job satisfaction. While limited, positive effects, such as greater job autonomy, improved commitment, increased motivation and higher satisfaction were reported in some of the studies reviewed. The authors suggest the ambiguity in the results stems from differences in implementation, practice and context. It is also quite possible that the predominantly negative effects reported may be attributable to the introduction of lean as a series of tools and techniques for cost cutting rather than as a management philosophy (Bhasin, 2012). To fully understand lean as a management philosophy or management system it is necessary to return to the origins of lean in Japan.

Following World War II, the Japanese car manufacturers were far behind the American manufacturers in terms of productivity and quality. Toyota undertook the challenge of catching up to the productivity standards of the American manufacturers. It was at this time that Taiichi Ohno, then working at Toyota's Koromo (Honshu) Plant, went to work on modifying the assembly process and created what is now known as the Toyota Production System (TPS). Ohno focused on the elimination of waste and excess in production processes. His methods came to be known as "lean" production with the publication of the book *The Machine That Changed the World* (Womack and

Jones, 2007) as they eliminate waste in all aspects of the manufacturing process including human effort, manufacturing space, capital investments, time, and inventory as compared with mass production. Toyota, in fact, set out to copy Ford's mass-production techniques but capital constraints and low volumes in the Japanese market did not justify the large batch sizes commonly used by North American car manufacturers. The advances made by combining the advantages of small lot production with economies of scale in manufacturing under what came to be known as the Toyota Production System (TPS) went largely unnoticed for many years (Holweg, 2007). TPS was not formally documented until 1965, and was not translated into English until 1977, with the publication of the article *Toyota Production System and Kanban System: Materialization of Just-in-Time and Respect-for-Human System* by Sugimori *et al*. (1977). By this time Toyota had a significant productivity advantage over European and American auto manufacturers. Their manufacturing methods were widely referred under the nomenclature of 'just-in-time' manufacturing or the 'Toyota Way' until the first publication of the book by Womack in 1990.

Interestingly, in the first English translation of TPS (Sugimori *et al*., 1977), the system is defined by the following two concepts:

> First of all, the thing that corresponds to the first recognition of putting forth all efforts to attain low cost production is "reduction of cost through elimination of waste." This involves making up a system that will thoroughly eliminate waste by assuming that anything other than the minimum amount of equipment materials, parts and workers (working time) which are absolutely essential to production are merely surplus that only raises the cost.
> The thing that corresponds to the second recognition of Japanese diligence, high degree of ability and favoured labour environment is "to make full use of the workers' capabilities." In short treat the workers as human beings and with consideration. Build up a system that will allow the workers to display their full capacities by themselves (p. 554).

The second concept, fundamental to TPS, emphasizes the importance of showing respect for people by eliminating wasteful movements, considering worker safety in job design, and allowing workers to display their capabilities by entrusting

them with greater responsibility and authority in decision-making (Sugimori *et al.*, 1977). Toussaint (2013) defines this important pillar of lean as creating work that is meaningful and safe. In a similar vein, Shook (2010) describes respect for people as "giving people the means by which they can successfully do their jobs, communicating clearly what their jobs are and providing the training and tools to enable them to perform those jobs successfully" (p. 68).

More and more western (particularly manufacturing) companies were emulating the Japanese methodology and techniques by this time, however, the focus on respect for people appeared to get "lost in translation"[22] (Halling and Renström, 2014; Pakdil and Leonard, 2015). This is surprising given that these concepts were not totally new; as far back as the 1920s there were calls for an "appreciation of the importance of the human factor" (Gordon Watkins, 1922 as cited in Kaufmann, 1993). The essence of the human relations perspective of the 1920s was that through effective motivation, communication and leadership in the workplace it is possible to create an organizational climate that promotes a mutuality of interests between management and labour and high levels of job satisfaction and productivity among employees (Kaufmann, 1993). These ideas were further developed by Elton Mayo, who viewed human nature as being driven by emotion and not by reason. Mayo and Roethlisberger's documentation of the Hawthorne experiments are presented in many textbooks as the foundation of human relations theory. Managers need to be concerned with what motivates workers and why, thus moving into a role of team builder and facilitator to enhance both job satisfaction and productivity, and not just the latter (Lemak, 2004).

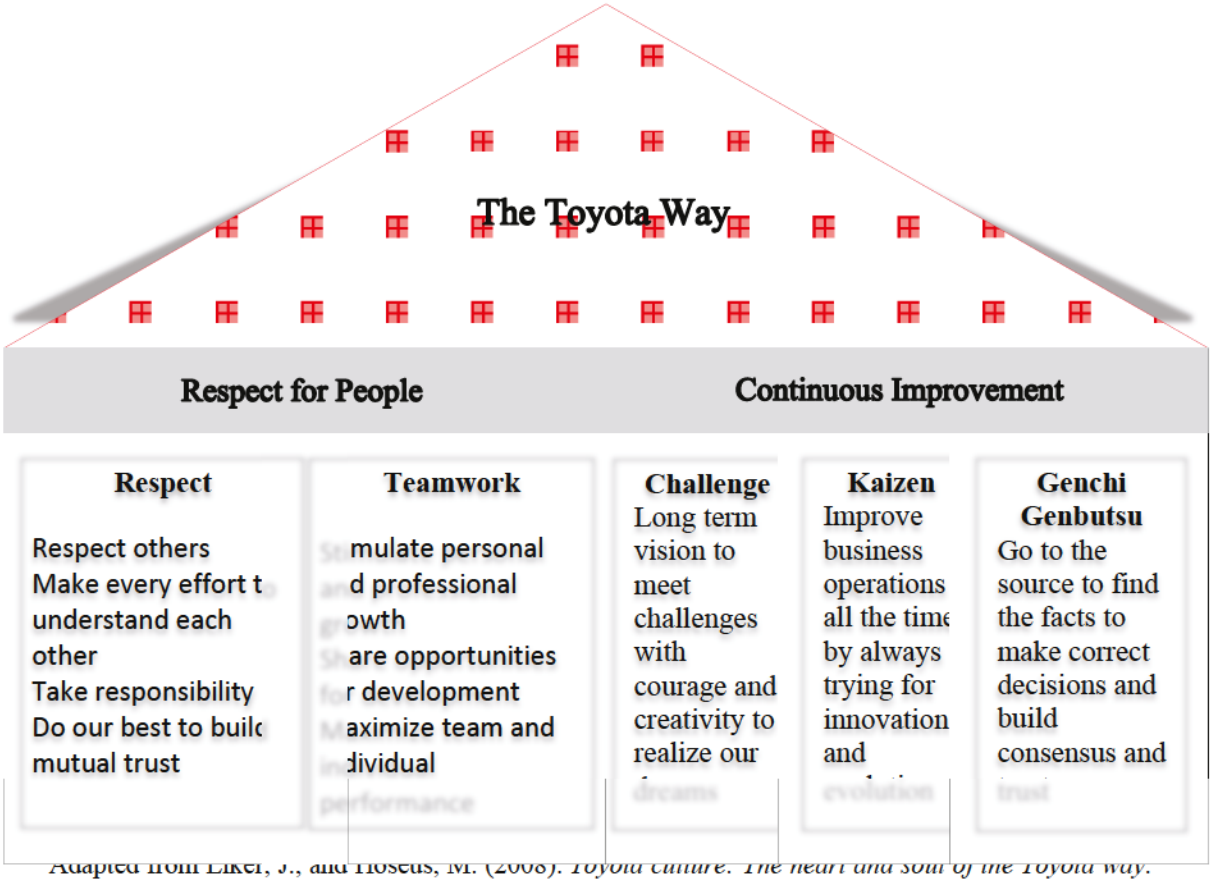
Another advocate of human relations theory in the 1920's and 1930's was Mary Parker Follett, a political scientist, social work pioneer and lecturer on management (Follett, 1995). Follett saw the organization as a social setting whereby individuals and

[22] This expression is taken from an article written by Fendt (2013) on the transfer of research findings to practitioners.

groups contribute to the overall success through participation in decision-making. It is not enough to transfer formalized power; individuals must be directly involved in analyzing problems and implementing solutions. In this way Follett moves away from the concept of a leader having power over a subordinate to the concept of sharing power with subordinates and developing their ability to be full partners in the organization (Eylon, 1998). While Follett was an American political scientist and philosopher, her work was more influential in Europe than in North America. It is not surprising then, given Follett's view of mutual problem solving, the use of cross functional teams, and flatter organizational structures, that her philosophical view of empowerment foreshadowed the development of lean principles and the Toyota Way (Feldheim, 2004). To properly understand lean it is, therefore, necessary to look beyond the tools and practices and understand the system itself.

The Toyota Way is based on two fundamental pillars: respect for people and continuous improvement. These key themes are presented in Figure 2.

Figure 2
The Toyota Way



Adapted from Liker, J., and Hoseus, M. (2008). *Toyota culture: The heart and soul of the Toyota Way.* Revised edition. McGraw Hill Professional.

Womack *et al.* (1990), credited with the term 'lean,' studied extensively the key principles of the Toyota Way. The five key principles of lean (value, value stream, flow, pull and perfection as discussed in the Introduction) are clearly documented in the book *Lean Thinking* (Womack and Jones, 2003). Any improvements made within a lean system are made in accordance with a standard scientific problem-solving method, under the guidance of a teacher (understood to be the hierarchal supervisor), at the lowest level possible within the organization. Frontline workers make improvements to their own jobs and their supervisors provide assistance. As Holweg (2007) states, "it is this dynamic learning capability that is at the heart of the success of the Toyota Production System" (p. 422).

Lean has been used to describe many things including manufacturing processes, organizational culture, organizational philosophy and the management system. Lean production and lean manufacturing are used interchangeably to describe a production system that, when implemented, provides a way to produce more and more, with less and less (less material, less effort) and comes closer and closer to providing customers with exactly what they want (Womack and Jones, 2007). Lean philosophy, on the other hand, is concerned more about changing the way people think than with the elimination of waste in the individual processes. As Radnor (2012) notes, lean is more than a process methodology; it is a philosophy expressed through management practices changing both the technical and cultural aspects of an organization. Mann (2005) indicates that an organization's management philosophy is reflected in its management system. Management systems within a lean philosophy ensure that decisions are made at the lowest organizational level possible, closest to where the actual work is being done. As well, they nurture a learning environment, systematically focusing on the customer, and promoting leadership at all levels (Mann, 2005).

It is important to note that Lean should not be seen as a panacea (Bicheno and Holweg, 2008; Radnor, 2011). The methodologies of Lean will not and cannot solve all organizational difficulties; they need to be accompanied by the underlying philosophy, which is clearly one that reflects more contemporary theories of management, specifically those that were introduced during the human relations movement. It is a philosophy that believes in human agency and is rooted in the belief that workers are self-motivating. It also reflects Mintzberg's (2009) view of the importance of rebuilding companies as communities. When he speaks of communities, Mintzberg indicates that organizations work best "when committed people work in cooperative relationships based on respect." (p. 3).

Successful implementations require a fundamentally different philosophy and management system than that of classical management philosophies, or in the words

of many authors, a change in organizational culture. Prior to exploring the construct of organizational culture, we will now look at how lean has been translated to the healthcare sector and review the scientific literature on lean healthcare implementations.

1.2. Lean Healthcare

Public reform has been on the agenda since the 1970s (Radnor and Osborne, 2013). New Public Management (NPM) is a cluster of ideas and practices that seek to use private sector approaches in the public sector; in other words, to run public organizations like businesses (Denhardt and Denhardt, 2000). NPM replaces the tenets of 'old public administration' (synonymous with bureaucracy, hierarchy and control) which include:

A. A centralized bureaucracy as the best choice of organizational structure as it is the most efficient for service delivery;
B. Programs are implemented through top down control mechanisms;
C. Citizen involvement is limited as bureaucracies are closed systems;
D. Efficiency and rationality are the most important values;
E. Public administrators do not participate in policy making but are charged with efficient implementation of public objectives.

NPM initiatives include efforts to improve productivity, an emphasis on accountability, the redefinition of organizational missions, streamlining of processes and decentralization of decision-making (*Idem)*. Lean is the most commonly used business improvement method (Radnor, 2012) transferred from the private to the public sector (Radnor, 2012).

In healthcare, the drive to reduce the startlingly high number of medical errors, medication errors and central line infections causing injury or death (Spear, 2005) along with the rising cost of healthcare due to an aging population has also led healthcare organizations to adopting business improvement methods from the private sector. Scientific research on lean in healthcare was first published in North America in 2002 (de Souza, 2009; Drotz and Poksinska, 2014). Overwhelmingly, the literature

describes lean in terms of the five principles documented in *Lean Thinking* (Womak and Jones, 2003). As mentioned previously, the focus and success of TPS lies in the dynamic learning capability inherent in the system; and in the fundamental belief that people are the most important corporate asset. Investment in their skills and knowledge is essential to building competitiveness (Spear and Bowen, 1999). These elements, however, are generally absent from the scientific literature concerning lean healthcare.

There is a dominance of studies in the scientific literature reporting successful lean interventions in healthcare (Mazzocato, Savage, Brommels, Aronsson, and Thor, 2010; Mazzocato, Holden, Brommels, Aronsson, Bäckman, Elg, and Thor, 2012). Some commentators indicate that this may be due to a publication bias that highlights favourable results (Joosten, Bongers, and Janssen, 2009). With few exceptions, the articles reviewed for the preparation of this theoretical framework describe the benefits of lean healthcare and successful implementations. One of the few articles critical of lean healthcare was not a scientific research article, but a publication in the Huffington Post[23], scathingly enumerating the perverse effects of the lean method: deterioration of the work climate; disrespect for professional deontology due to changes in clinical practice; dehumanization of healthcare due to the focus on productivity; and breaches in conditions of collective agreements. While the publication is not backed up with empirical evidence, it does reflect the position of other articles commenting on the negative effects of lean in the manufacturing sector (e.g. Boje and Winsor, 1993), and reflects on how lean is implemented (as a cost-saving tool) and a lack of understanding of the underlying philosophy.

Implementation of lean in general and specifically in healthcare varies tremendously. As mentioned in the Introduction, there are few examples of excellence. Many of the barriers to implementation in healthcare are similar to the barriers documented in the research in the manufacturing sector. There are, however, several

[23] Boudou-Laforce, *Le Huffington Post*, 2013

that are unique to healthcare (de Souza and Pidd, 2011). The barriers identified by the authors that are unique and/or particularly difficult to overcome in healthcare are summarized in Table 2.

Table 2
Barriers to Lean Healthcare

Barrier	Description
Perception	Lean principles are appropriate for manufacturing environments where products are produced, but not for healthcare when the 'product' is a patient.
Professional skills	Healthcare professionals are excellent at solving problems immediately, creating workaround solutions to meet the specific needs of a patient. Root cause problem solving is not part of their mentality. Decisions are experienced based and not data/evidence-based. As experts, managers are reluctant in giving up decision-making control, making employee involvement difficult to achieve.
Professional and Functional Silos	The fragmentation of healthcare into silos (professional and functional) impose a major barrier to flow, and consequently to the implementation of lean techniques. Within the healthcare sector there is a certain level of discomfort with inter-professional collaboration.
Performance Measurement	Data collection and daily measures on processes and patient outcomes are not readily accessible. There is resistance to implementing due to patient safety and confidentiality concerns.
Hierarchy and Management Roles	Management roles are designated based on technical/professional skills and not on managerial/leadership skills. As excellent practitioners, managers see their roles as coming up with a solution once a problem has been identified.
Defining the customer	While the obvious customer is the patient, many institutions consider other stakeholder groups such as the clinical practitioners or ministry representatives as the customer, given that the patient does not pay for services provided.
Disjointed application and tool-based approach	The most prominent method implemented in healthcare is the rapid improvement event (RIE or Kaizen) for short-term gains in process productivity. These activities are focused at the department level and are not linked with organization-wide activities.
Lack of top management focus and involvement	The lack of a strategic direction and vision as it relates to lean implementation in addition to a lack of involvement and commitment to providing the resources and training necessary.

Adapted from de Souza and Pidd (2011); with additions and corroboration from: Ben-Tovim *et al.* (2007); Burgess and Radnor, (2013); Drotz and Poksinska (2014); Fradhino *et al.* (2013); Jadhav *et al.* (2014); Joosten *et al.* (2009); Mazzocato *et al.* (2012); Radnor *et al.*, 2012; Sobek and Lang (2010); Young and McClean (2009).

While the barriers are imposing and may lead to thinking that the transfer of practices from the private to the public sector is not possible (Radnor, Holweg and Waring, 2012; Timmons *et al.*, 2014; Waring and Bishop, 2010), other studies indicate that it is possible and points to several facilitating factors.

The first facilitator, widespread involvement, emphasizes the importance of getting all members of the organization involved in lean. Front-line employees need to be engaged in problem solving, with supervisors and managers close by facilitating and coaching the process. Physicians and administrators also need to actively participate and collaborate to allow for the alignment of improvement projects across departmental boundaries (Sobek and Lang, 2010). Widespread involvement also means training for all employees on lean principles and the lean philosophy. This training should, however, focus on learning in action and not simply the theory (Atkinson, 2010). Second, the organization should demonstrate commitment to and support for lean implementation through not only the provision of sufficient resources (dollars and time) for training and development, but also a willingness to modify the organizational structure to a flatter, and decentralized organization to promote empowered decision-making and collaboration. Third, dedication to improving the patient and family experience should be the focus of all activities within the organization (Toussaint and Berry, 2013; Weber, 2006). This unity of purpose provides coherence between strategic objectives, day-to-day activities and large-scale improvement projects (Foropon, Landry, Beaulieu, and Mclachlin, 2013; Mannion, Davies and Marshall, 2005; Radnor and Walley; 2008; Toussaint and Berry, 2013). Dedication to improving value for patients also means involving them in improvement projects (Wellman, Jeffries and Hagan, 2011), and conceptualizing care services as part of an overall trajectory taking the patient from admissions, through all of the departments required for care, to final discharge (Ben-Tovim *et al.*, 2007; Ben-Tovim, Dougherty, O'Connell and McGrath,

2008). The fourth and final facilitator is aligning the espoused value of respect for people with the inferred values demonstrated through behaviour. Behaviours that infer the value of respect for people include: investing in training and development; physical presence and involvement in lean activities; and demonstrating that while the ultimate goal is to improve patient outcomes, this is done by improving the working conditions of the care givers (Drotz *et al*., 2014, Radnor *et al*., 2012).

In a briefing, published by The Conference Board of Canada in 2015, the authors, MacKenzie and Hall, identify three different levels of transformation conceptualized as a journey or continuum. The levels of transformation are inspired by Dr. Shigeo Shingo, the industrial engineer that developed the Toyota Production System, and illustrated by several Canadian examples of attempts at lean transformation in the healthcare sector (i.e. BC Provincial Health Services Authority and the province of Saskatchewan healthcare network). The tool-driven level represents the starting point of most organizations' lean journey. At this stage an emphasis is made on the tools and techniques, and improvement initiatives are generally disconnected from others within the organization. At the system-driven level, tools are applied in a more strategic manner; focused in areas that help the organization to meets its strategic goals. At the final level, the principle-driven level, lean principles are embedded in the organization's culture.

At the tool-driven level, organizations may generate fairly significant short-term improvements, however, they are not enough to generate transformational change (MacKenzie & Hall, 2015). Moving to the system-driven level requires a shift from a 'doing' organization to a 'thinking' organization. Lean efforts are directed towards strategic objectives, and process improvements shift from individual departments to across departments. This requires a shift from functional silos to collaboration. It is at this stage that many organizations stall in their transformation as they try and manage the conflicting needs of different units and implement lean principles to the value stream, in addition to moving from a short-term to a long term perspective (*Ibid*). While

the focus of the first level is problem resolution, and the focus of the second level is goal orientation, the focus at the third level is "learning through reflection" (*Ibid*, p.25). It is at this level that an organization captures the essence of lean, which Holweg (2007) describes as a dynamic learning capacity. Here, lean loses its individual identity and becomes embedded in management practices; the principles and philosophy are fully integrated into daily activities.

The literature review has suggested that lean implementations vary greatly, depending on the organizational context and their starting point. The approach articulated in the literature, and by organizations that have successfully implemented an integrated management system based on a lean philosophy lean is similar: patient well-being is critical, supporting people who work in hospitals is essential and sustainable long-term change that is broad and deep is the only answer. Organizational culture is identified as a critical element in implementing and/or the organization's culture is presented as a barrier to the implementation of lean in all sectors (Atkinson, 2010; Badurdeen, Wijekoon, and Marksberry, 2011; Bortolotti, Boscari and Danese, 2015; Bhasin, 2011, 2012; Burgess and Radnor, 2013; Chassin, 2013; Jadhav, Mantha and Rane, 2014; Mannon, 2014; Sobek and Lang, 2010; Toussaint and Berry, 2013). Elements that are included under the banner of culture in the lean and lean healthcare literature include values, beliefs, shared understandings, leadership and patterns of behaviour; however, often the researchers lump almost everything under the cultural banner, and do not operationalize the concept. The next section will explore the general construct of organizational culture and the various perspectives evident in the scientific research.

1.3. Organizational Culture

The research domain of organizational culture is a relatively recent addition to management research. While Pettigrew (1979) is most often cited as the first researcher to apply concepts of culture to the organization with his longitudinal study concerning language, beliefs, symbols, and myths and their contribution to the creation of a very

specific organizational culture within a school, British sociologist Elliot Jaques was in fact the first organization theorist to bring the culture concept to organizational studies with the publication of his book *The Changing Culture of a Factory* in 1952 (Hatch and Cunliffe, 2013). However, it was not until the 1980s, shortly after the publication of Pettigrew's (1979) article that the concept began to take hold in organizational theory. Around the time of the publication of his article, there was an increasing shift to a knowledge economy. Companies were moving from more mechanistic and highly centralized to more decentralized and organic organizational forms, generating interest in aligning towards a common goal through idealistic values rather than through hierarchal directives (Alvesson, 2013). This is the same period that the Toyota Production System was gaining in popularity given its superiority over traditional mass production methods conventionally used in the American car industry. More and more researchers became interested in organizational culture as a compass, or as the social glue, binding an organic organization together, providing direction and focusing efforts towards common objectives.

Over the last forty years, definitions and conceptions of organizational culture have not converged (which is probably true for the majority of fields of organizational theory). The theoretical roots of organizational culture may be found in anthropology, sociology, social psychology and management studies (Ouchi and Wilkins, 1985). While there is no consensus on a definition of culture, most authors would agree that the construct includes the following common characteristics (adapted from Alvesson and Sveningsson, 2008; Hofstede, 1980; Ogbonna and Wilkinson, 2003): a) it is holistic involving large groups of individuals; b) it is historically determined and is conveyed through traditions and customs; c) it is related to anthropological concepts; d) it is socially constructed and dynamic; e) it is soft, vague, multifaceted and layered referring to ways of thinking, values and ideas of things more than to the visible parts of an organization; and f) difficult to change as people tend to hold on to their ideas, values and traditions.

The literature on organizational culture may be divided based on the theorist's philosophical tradition. Within the modernist philosophical tradition, culture is viewed as a critical independent organizational variable "shaping the beliefs and behaviours of individuals" (Ouchi and Wilkins, 1985, p. 462). Within this stream, researchers attempt to understand the link between culture and performance and propose ways that it may be used as a lever to improve performance (Alvesson, 2013; Martin, 2002; Smircich, 1983). Books by Peters and Waterman, and Deal and Kennedy first published in 1982 promote the idea that strong cultures breed excellence (Hatch and Cunliffe, 2013).

Researchers within this stream look for abstract universal dimensions of culture that may be measured with surveys, looking for general traits of culture (Schein, 2009). The studies, in general, are narrowly focused on a few cultural manifestations demonstrating a belief that if other manifestations were studied they would provide similar findings. In addition, culture is believed to be cohesive and representative of the entire organization. This is the integration perspective as defined by Martin (2002), whereby managers are responsible for creating and sustaining the cohesive framework of the organization's culture. The competing values framework (Cameron and Quinn, 2011) is the most used evaluation method in healthcare for understanding organizational culture (Ovseiko and Buchanan, 2012). The assessment instrument creates a culture profile constructed from an assessment of six dimensions. The dimensions are based on a theoretical framework of how organizations work and the kinds of values on which their cultures are presumed to be founded.

The competing values framework was used in a study by Mannion *et al.* (2005) who identified cultural characteristics of "high" and "low" performing hospitals in the UK National Health Service. Their study focused on senior management perceptions of patterns of behaviour, beliefs and values as well as visible artifacts such as patterns of behaviour, systems of patronage and rewards, and accountability processes. Performance of the hospitals was determined by government ratings. Through a multiple case study design, four cultural categories emerged, around which there was

a divergence between the high and low performing groups. The authors do caution, however, that links between culture and performance are complex and, hence, causal relationships may not be determined, suggesting that culture and performance most likely develop in a recursive manner. The relationship between culture and performance is in fact much weaker than suggested in some of the popular management literature (Davies and Mannion, 2013).

Researchers within the postmodernist philosophical tradition echo these doubts concerning both the ease with which culture may be manipulated by managers, and the true nature of the culture performance link. Contrary to the modernist view of culture, within the postmodernist philosophical tradition, culture is a root metaphor for the organization; it is not a variable of the organization but 'is' the organization (Alvesson, 2013; Martin, 2002; Smircich, 1983). Organizational culture determines strategy, structure and required leadership. In this stream, an organization is an expression of human consciousness; it is a social phenomenon (Hatch and Cunliffe, 2013). Researchers of this stream are interested in providing deep and rich understandings of organizations, in connecting behaviour to strategic management and "connecting the organization as a whole with everyday experiences and individual action" (Alvesson, 2013, p. 7). The scientific literature attempts to reveal nuances, details and dynamics of a particular culture through interviews and intervention, uncovering cultural processes rather than cultural manifestations (Schein, 2009). Studies take an ethnographic perspective, and explore all possible manifestations providing a rich description of a single context. Language, symbols, myths, stories and rituals are of importance, not as cultural artifacts, but as processes that create and shape meanings that may be reinterpreted and renegotiated allowing organization to be accomplished (Alvesson, 2013).

Smircich (1983) indicates when researchers see culture as a root metaphor for the organization they tend to draw on a view of culture based predominantly in either cognitive or symbolic anthropology. From a cognitive perspective, culture is seen as

"a system of shared cognitions or a system of knowledge and beliefs" (Smircich, 1983, p. 348). This system forms a frame of reference, which in turn informs action. As with the notion of research paradigms found in the scientific community, these frames of reference provide a certain worldview of what is considered legitimate thought and appropriate action (Smircich, 1983). These basic assumptions are very difficult to study as they are often taken for granted and difficult to explicitly express (Hatch and Cunliffe, 2013). From a symbolic perspective, culture is seen as "a system of shared symbols and meanings" (*Ibid*, p. 350). The focus is on how individuals interpret and understand their experience and how this understanding translates into action.

While many authors distinguish between the cognitive and symbolic theories of culture, Lakomski (2001) contends that human cognition (beliefs, values and assumptions), normally believed to be the property of the individual mind, is not radically separate from its external symbolic representation. The cultural meaning of an object is determined not only by an individual's cognitive schema but is also influenced by interactions with people who have a similar history. The merging of the two into one 'world' is based on connectionist theory, which is the basis of Strauss and Quinn's (1997) conception of cultural cognition. In very general terms, connectionism allows for a view of cultural meaning that ties the individual processes of cognition and the generation of schemas to the understanding that is rooted in experience and interaction.

The question of whether culture is shared by the entire organization is also debated in the literature; three perspectives are evident (Alvesson, 2013; Martin, 2002). The integration perspective, as mentioned in the critical variable stream, views culture as cohesive and shared by all organizational members. The second perspective of differentiation views organizational culture as several subcultures that coordinate and cooperate, however, not necessarily in harmony. Groups within the organization share common beliefs and understandings, yet there are differences between groups within the organization. The third and final perspective, fragmentation, places more emphasis

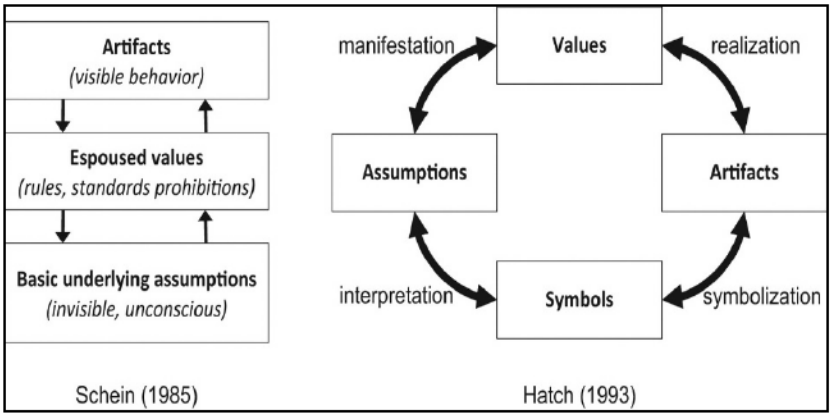
on ambiguity than on broadly shared understandings. Individuals within the organization each make sense of their surroundings, interpreting and giving meaning to everyday activities in slightly different ways. Meaning of daily activities is created continuously, within an overall framework of loosely shared assumptions. Based on the postmodernist view of culture as a metaphor for an organization, and the fragmentation perspective, it is unrealistic to believe that management has control over the interpretation and meaning making of employees. It is also unrealistic to believe that management is situated somewhere outside of the organization's culture able to see and influence it; they are as much a part of the daily interactions and meaning making that create and are created by organizational culture (Lakomski, 2001).

Manifestations of culture may be grouped into four categories: cultural forms (rituals, stories, jargon, humour, myths, physical arrangements); formal and informal practices (organizational structure, policies and procedures versus social rules and work practices) and espoused versus inferred themes (beliefs, values and assumptions) (Martin, 2002). Schein (2009) conceptualizes culture as a pyramid of manifestations, with the visible artifacts at the top, espoused values (strategies, goals, philosophies) at the second level and underlying assumptions (unconscious, taken for granted beliefs and perceptions which are the driving source of values and actions) at the deepest level. While Schein (2009) views these as distinct levels, other authors (e.g. Gagliardi, 1986; Martin, 2002) do not believe that there are varying levels of depth; artifacts are no more superficial than espoused values or underlying assumptions. Studies of culture, whether they focus on material manifestations or on senior management's strategy and objectives should strive to discover the underlying assumptions (*Ibid*).

Hatch (1993) offers a dynamic rather than a static model of the manifestations of culture, concentrating on the processes that generate the cultural elements. The author includes symbols as a cultural element distinct from artifacts. In the static representation of cultural elements provided by Schein (1995), Hatch (1993) would agree that distinction between symbols and artifacts is a difficult task. However, in the

author's cultural dynamics model, the focus shifts from the physical forms of cultural elements to the way the forms are produced and used by organizational members. A symbol may be defined as an object (word or statement, kind of action, or a material phenomenon), which represents something else, evokes emotion and leads to action (Alvesson, 2013; Pettigrew, 1979; Gioia, 1986). Hatch (1993), citing Cohen (1985), views symbols as more than simply representing something else, indicating that they also allow those that employ them to supply part of the meaning. Meaning may be defined as the interpretation evoked in a person by an object or event at any given time, while cultural meaning indicates the typical interpretation of a group of people because of similar experiences (Strauss and Quinn, 1997). The symbolization process in the cultural dynamics model explains how certain artifacts are infused with meaning based on the experiences of organizational members, and how this symbolic meaning may influence the way in which organizational members regard certain artifacts, and thus shows why not all artifacts are necessarily symbols. The reciprocal interpretation process links symbols to assumptions. Two possibilities of interpretation exist according to Hatch (1993): an alternative understanding of a symbol based on current assumptions, or a revision of current assumptions based on a new understanding of a symbol. Hence, the cultural dynamics model, as with Strauss and Quinn's (1997) conception cultural cognition, also blurs the distinction between cognitive and symbolic theories of culture, proposing instead that cognition cannot be separated from the social interaction with symbols that create their meaning. Figure 3 presents Schein's model (1985) of cultural manifestations and Hatch's (1993) model of cultural processes.

Figure 3
Comparison of Schein's (1985) Model of Cultural Manifestations and Hatch's (1993) Cultural Dynamics Model



Given the previous discussion on the various perspectives of organizational culture, how may it be defined? The following definitions are indicative of how organizational culture is viewed in the present study:

> Culture is the creation of meaning through which human beings interpret their experiences and guide their actions (Geertz, 1973, p. 145).
>
> Culture is best understood […] as something people do; it is emergent, dynamic, situationally adaptive and co-created in dialogue (Alvesson, 2013, p. 4).
>
> Culture is regarded as a more or less cohesive system of meanings and symbols, in terms of which social interaction takes place (Alvesson, 2013, p. 5).
>
> Cultures place diverse humans within a shared framework of belonging, which they express through a multitude of artifacts and symbols, only a key few of which do they all acknowledge. And even when a symbol is widely shared it will most likely carry multiple and conflicting meanings (Hatch and Cunliffe, 2013, p. 159).

Within these definitions, are several conceptual assumptions: organizational culture is dynamic and created through interaction; it is not cohesive—individuals create systems of meanings and symbols where the exact meanings are not necessarily shared by all members of the organization; and meanings and symbols are the most significant manifestations of organizational culture. Based on my philosophical stance

and the conceptual assumptions made concerning organizational culture, the following definition will guide my doctoral research:

> Culture is a loosely structured and incompletely shared system of symbols and meanings that emerges dynamically in interaction as cultural members experience each other, events and the organization's contextual features. Interaction may either lead to reinforcement of or change to symbols and meanings.

This definition is adapted from an anonymous reviewer (1987) cited in Martin (2002, p. 58). Settling on a single definition has been done with a certain level of discomfort, as "no single definition of a construct in social science is likely to do justice to its complexity" (Williams, 1968, p. 283, cited by Hofstede, 1980, p. 16). Adopting this particular definition of the construct means that I have committed to the conceptual assumptions as mentioned above, and these assumptions will lead to the specific way in which the research will be conducted (Allaire and Firsirotu, 1984), as will be discussed in Chapter 3.

1.4. Organizational Culture Change

As with all streams of organizational research, organizational culture change theories are influenced by the philosophical tradition and interpretive framework of the authors. To understand the roots of organizational culture change theory, it is first necessary to briefly look at the broad context of organizational change, and then situate organizational culture change within this field.

Understanding how and why organizations change has been the subject of much of the scientific research in the field of management over the past seventy years. Many authors, in an attempt to introduce some order into the diverse field of organizational change, have presented syntheses or typologies of the field. As Demers (2007) has done, the organizational change theories discussed in this section will be organized historically.

The themes reflect to a large extent the economic context of the three historical periods. The 1950s were marked by a period of optimism and growth following the end of World War II, and change was viewed as positive; an opportunity equated with prosperity. Researchers from the first period generally were interested in looking at change from outside of the organization (what causes organizations to change and why some organizations remain while others disappear). With increased competition in the second period, the external environment began to be viewed as a 'jungle' and scientific interest turned to the role of top managers in driving organizational change. The third period is marked by a dramatic increase in the speed of change making the capacity for change of the organization a key requirement for survival. Approaching the turn of the century, scholars became more interested in how change was generated from within various levels of the organization on a continuous basis, concentrating much more on the process of change. The prominent theories within each of these perspectives are summarized in Table 3.

Table 3
Historical Summary of Organizational Change Theories

View from Outside	View from Above	View from Within
		
1950 1960	1970 1980	1990 2000
growth economy change as an opportunity	competition/jungle change as a threat	change capacity for survival change as intrinsic
planned change episodic change in states unitary view		emergent change change is processual and dynamic pluralistic view
deterministic/structure	voluntary/top level agency	combination (structuration)
<u>Rational & Organic Adaptation</u> Contingency Theory Insitutionalism Theory of Organizing Life Cycle Theory <u>Selection & Imitation</u> Population Ecology Neo Institutionalism	<u>Transformational Change</u> Configurational Approach Cultural Approach Cognitive Approach	<u>Natural Evolution</u> Behavioral Learning Evolution Complexity Political Approach <u>Social Dynamics</u> Discursive Approach Practice Centered Approach Radical and Post-Modernist

Note: This classification is not an exhaustive summary of all existing organizational change theories, but an overview of the major theories from approximately 1950 to 2000 based primarily (yet greatly simplified) on the work of Demers (2007). Other sources include: Kilduff and Doughtery, 2000; Nasim an Sushil, 2011; Weick and Quinn, 1999.

Classifying organizational change theories historically is very difficult to do, as several theories of change classified under the theme of 'change viewed from within' appeared much earlier than the 1990s (for example Weick's work on sense-making). Nevertheless, the historical categorization does allow us to see the influence of external factors on how change in organizations is viewed. The historical overview of organizational change theories also highlights a move from a mostly modernist philosophical tradition to postmodernist as evidenced in the opposing view of change as either episodic and planned or processual and emergent. A conceptual review of the organizational change literature by Nasim and Sushil (2011) highlights a shift from an

approach of trade-offs (either-or) to paradoxical thinking (and/also). Theories that embrace paradoxical thinking, transcend the seeming opposition of concepts, and propose novel and alternative viewpoints to the traditional literature (Abdallah, Denis and Langley, 2011).

One of the dominant divisions of the organizational change literature is the view of change as incremental and continuous versus change as episodic and transformational. Weick and Quinn (1999) provide an analysis of the organizational change literature, comparing episodic and continuous change and highlighting the distinction in the paradigm of the organization held by those within each viewpoint. Within episodic change the organization is viewed as inertial, whereas within continuous change the organization is viewed as emergent and self-organizing. Transformation in episodic change comes from planned change, initiated by management moving the organization from one state to another. Transformation in continuous change is the accumulation of decisions, actions and interactions, sometimes planned, sometimes spontaneous that happen daily within the organization. The authors conclude that "reconciliation of these disparate themes is a source of ongoing tension and energy in recent change research" (p. 381) and suggest that researchers focus more on 'changing' than on 'change.'

Tsoukas and Chia (2002) do just this, defining the reality of the organization as constant change and introducing the notion of organizational 'becoming.' 'Becoming' presupposes that reality is continuously changing and in the process of 'being'; there are no fixed entities, only transitions. Emphasis is on process, interaction and relatedness instead of on outcomes. In other words, organizations are seen "both as quasi-stable structures (i.e. sets of institutionalized categories) *and* as sites of human action in which, through the ongoing agency of organizational members, organization emerges" (Tsoukas and Chia, 2002, p. 580). Langley and Denis (2006), propose a vision of change that integrates the view of episodic change with organizational becoming, adopting the terminology employed by Orlikowski (1996) of situated

change. From this perspective, intentional large-scale changes are viewed as a shock to a system that is continuously evolving. The intended change both modifies the system in which it is introduced and is modified by the system. A perspective of situated change challenges the more dominant normative scientific literature on managing change, which neglects the recursive, endogenous and political nature of change (Langley and Denis, 2006).

A significant amount of the scientific literature on organizational change approaches change from a cultural perspective. As noted by Alvesson and Sveningsson (2008), "much of existing writings and of projects on organizational change involves organizational culture in one sense or another. Culture is often seen as either the key issue to be changed or something that is crucial to take seriously in order to make change possible" (p. 3). Culture appears to be of particular importance in the healthcare sector given the significant differences in meanings, and symbolism between private and public organizations (Lozeau *et al.*, 2002).

The cultural approach to organizational change became popular in the '80s, as mentioned earlier, as organizational researchers, particularly from the culture as a critical variable perspective, began linking high performance to a strong culture. Change theories of this era mainly concentrated on change as viewed from the top of the organization (Demers, 2007), and began questioning the position of the previous period of change as gradual adaptation. Organizations begin to be viewed not as loosely coupled systems, but tightly coupled and highly interdependent systems. Change is viewed as revolutionary and initiated by top managers to reposition the organization. Within this period, the debate over the capability of managers to direct and manage change increases in intensity reflecting the differing viewpoints of the managerialists (or functionalists) and interpretivists.

The cultural approach to change is a derivative of the configurational approach, which takes a holistic, systemic view of change, looking at the interaction of all the

parts of the organization that incrementally changes in response to environmental changes, until the configuration is no longer aligned, or the change within the external environment too large to respond to with incremental change, forcing a reorientation represented by radical transformation of the organization. Within the configurational approach, an organization is viewed as a gestalt and change is viewed as revolutionary; the gestalt must be torn apart and reconfigured to reposition itself within the environment. The most prominent of the configurational theories is the punctuated equilibrium model (Demers, 2007). An organization is configured such that its structure, processes, technology, and strategy lead to certain performance results. The organization makes several small and convergent changes to the configuration in line with the current strategy and performance level until a transformation of the configuration is required in response to large environmental or internal change (Miller and Friesen, 1982; Romanelli and Tushman, 1994).

The cultural approach, however, moves away from looking at change based on the technical aspects of the organization (strategy, structure) and looks more to the social and symbolic dimensions. Theories on culture change are varied and depend on the author's perspective of culture. As mentioned in the section on organizational culture, there are three general perspectives: unitary, differentiated and fragmented. The dominant view (that of functionalists) is of culture as unitary, cohesive and shared, and therefore, change is viewed as "a monolithic process, […] an organization-wide phenomenon" (Meyerson and Martin, 1987, p. 628). Organizational transformation implies a cultural revolution (Allaire and Firsirotu, 1984), led from the top of the organization, moving the organization from point A to point B, through a series of steps based on Lewin's three fundamental steps of unfreezing, change and refreezing. Many believe that organizational development (OD), due to its focus on the whole organization, system-wide change or transformation over time, and on meanings, is the precursor to the organizational culture change literature (Lewis, 1996). Research on culture change includes an enormous amount of scientific research on n-step theories of change. There is a wide variety of variation in the number of steps, however, the

majority includes the creation and sharing of a vision of the change, the detailed planning of the deployment steps (which includes the three-step approach of Lewin), and the evaluation of the change program (Audet, 2010).

Interpretivists, who take an organizational stance, believe that implementation issues are neglected by managerialists, and argue that change is more evolutionary and emergent than revolutionary and planned. Based on this perspective of culture, change is dynamic and continual, occurs as new meanings are negotiated between organizational members, and is anchored in everyday communication and dialogue (Alvesson, 2013). Regardless of the viewpoint, change viewed from the top of the organization looks at change as a sequence of events rather than as a difference in states predominant in looking at change from the outside.

The differentiation and fragmentation perspectives of organizational culture tend to view culture change as emergent in nature, and less controllable by top management. Change from the differentiation perspective of culture concentrates on the interplay between subcultures in an organization (Meyerson and Martin, 1987). The authors describe this type of cultural change as more incremental than revolutionary. Conceiving of the organization as an open system, the differentiated perspective on change points to environmental sources of localized change impacting subcultures that are loosely coupled together. These changes are often not planned nor controlled by top management and culture change from this perspective may or may not be organization-wide.

Within the fragmentation perspective, culture change is viewed as dynamic and continuous and all cultural members, including leaders, change and are changed by the organizational culture (Meyerson and Martin, 1987). While the differentiation perspective of change points to environmental factors as the source for cultural change, the fragmentation perspective focuses more on artifactual interactions, symbolization

and interpretation processes that maintain or modify shared meanings (Cook and Yanow, 1993; Hatch, 1993).

An integration perspective dominates the research literature on culture change, as previously mentioned[24]. In addition, it is also dominated by reports of successful attempts to change culture. Very little of the research provides lessons learned from failed culture change programs. Nevertheless, Alvesson and Sveningsson (2008) provide an exhaustive case study of an attempted culture change that failed, providing rich insights into the experiences of people at all levels of the organization over the duration of the change. The authors are advocates of processual studies and the use of multiple perspectives to better understand the dynamics of complex changes. Their study, similar to Harris and Ogbonna (2002), underscores the unintended and undesired consequences that result from planned change, particularly if managers believe that culture is a variable and people are simply transporters of the force of change generated at the top of the organization.

As with the cultural approach, the cognitive approach is a derivative of the configurational view of organizational change. The cognitive approach focuses specifically on the adoption or construction of a new interpretive schema and provides a psychological explanation for radical change (e.g., Greenwood and Hinings, 1993; Ranson, Hinings and Greenwood 1980). Organizational change in the cognitive approach is viewed as reframing, either as a modification to the existing interpretive schema (first order change) or a change to a new schema (second order change) (Bartunek, 1984). The dominant opinion within the cognitive approach is that managers are the initiators and guardians of the organizational schema as they have the capacity and knowledge to understand and interpret the organizational context. Their knowledge structures, therefore, become the organization's schemata. Within the practice-centred

[24] Martin (2002) provides a list of examples of single-perspective cultural studies indicating a much more even distribution of research between the three perspectives; in contrast, the sampling of literature reviewed for the theoretical framework of this study demonstrated a bias towards the integration perspective.

view of change, organizations are viewed as "evolving communities of practice, as inherently temporary, unstable, and context-specific patterns of action and interaction" (Demers, 2007). Researchers are interested in the micro changes that take place as people go about their daily work, and the improvisational learning that occurs through interaction.

The creation of a culture viewed as a dynamic learning process may be found in works by Gagliardi (1986) and Schein (2009). Gagliardi (1986), similar to Schein (2009), identifies different levels of cultural elements. While Schein (2009) provides a hierarchy of the elements (visible artifacts at the top, espoused values [strategies, goals, philosophies] at the second level and underlying assumptions [unconscious, taken for granted beliefs and perceptions which are the driving source of values and actions at the base]), Gagliardi (1986) distinguishes between primary (enduring elements such as values and assumptions) and secondary elements (elements that are easier to modify such as behaviours, symbols and artifacts). The distinction proposed by Gagliardi (1986) leads to three types of possible culture change: apparent cultural change, cultural revolution, and cultural incrementalism.

Apparent cultural change represents a first order change of behaviours, with no change to the underlying assumptions. Revolutionary change occurs when the new culture (values and assumptions) is antagonistic with the present culture. This type of change requires strong leadership and is most often associated with a new organizational leader. New values and assumptions are introduced in the organization inciting different behaviours. These behaviours lead to a collective experience of success and the stabilization of the new values in the symbolic field (Gagliardi, 1986). The author questions whether cultural revolution can in fact be considered culture change, indicating that the revolution is more akin to the death of an organization and the rebirth of a new organization.

For Gagliardi (1986), incremental change represents the most desired type of culture change. It occurs when new values and assumptions are introduced that are different, but not antagonistic, with the current culture. In incremental culture change, leaders are facilitators not heroes, and subordinates are encouraged to experiment with new competencies, leading to collective success, and the insertion of the new values within the existing hierarchy of values, which ultimately results in the consolidation of new behaviours and new values and assumptions, considered as second order change. This view of culture change is very similar to Hatch's (1993) dynamic model of culture, and very much in line with the definition of culture as proposed in this research study.

Within the culture change literature (whether from a cultural approach, a cognitive approach, a social dynamics perspective, or a practice-centered view), the change to underlying values, assumptions and meanings at the root of organizational culture is seen to occur through a learning process. The scientific literature on organizational learning offers a variety of theories on this process, which are discussed in the next section.

1.5. Organizational Learning

The body of work on organizational learning may be classified either as descriptive or normative (Robinson, 2001). The descriptive approach seeks to understand how organizations learn and adapt, while the normative approach is interested in documenting how organizations can direct their learning to improve their performance. These two distinct strands are generally recognized under the labels of organizational learning or the learning organization. Most authors may clearly be situated in one of the two strands identified by Robinson (2001). For example, the works of Senge (2006) may be identified as part of the literature on the learning organization, while authors such as Weick (1991) Clegg, Kornberger and Rhodes (2005) and March (1991) contribute to the literature on organizational learning. The works of Argyris and Schön bridge the descriptive/normative divide. The authors are committed to improving practice; nonetheless, they have conducted a large number of

empirical studies to describe the process of organizational learning (Robinson, 2001). The scientific literature on organizational learning is of particular interest within the conceptual framework of this study, given its association with organizational culture change.

Organizational learning has its roots in two different approaches to culture change; the cognitive approach and the natural evolution approach of behavioural learning. As mentioned in the previous section, the change in mental frames of references referred to in the cognitive approach places more of an emphasis on radical change. Behavioural learning, on the other hand, places more emphasis on the emergent and incremental nature of change. Learning from this perspective is based in experimentation, where learning becomes embedded in routines (March, 1991). Behavioural learning is viewed as the exploitation of existing knowledge and less as an innovative change process (Demers, 2007). From the behavioural learning perspective, learning does not necessarily imply foresight or intentionality, but may instead be evidence of adaptation to day-to-day changes in the world. Fiol and Lyles (1985) contend that cognitive and behavioural learning are separate phenomena and one does not necessarily reflect the other. Changes in behaviour may occur with no development in cognitive association and similarly learning may occur with no change in behaviour. The authors associate behavioural and cognitive learning to lower (behavioural) and higher (cognitive) levels of learning. Table 4 provides a summary of these levels.

Table 4
Levels of Learning

	Lower-level	**Higher-level**
Characteristics	Occurs through repetition	Occurs through use of heuristics and insights
	Routine	Non-routine
	Control over immediate task, rules and structures	Development of differential structures, rules, etc. to deal with lack of control
	Well-understood context	Ambiguous context

	Occurs at all levels of the organization	Occurs mostly in upper levels
Consequences	Behavioural outcomes	Insights, heuristics, and collective consciousness
Examples	Adjustments in management systems	Agenda setting
	Problem-solving skills	Problem-defining skills
		Development of new myths, stories and culture

Reproduced from Fiol, C. M. and Lyles, M. A. (1985). Organizational learning. *Academy of Management Review*, *10* (4), 803–813, p. 810

Lower level learning, or behavioural adaptive learning implies that learning from trial and error becomes embedded in organizational routines. This type of learning, often identified as exploitation, is related to changes or refinement of existing routines (March, 1991). Exploitation is about creating reliability from experience, relying on behavioural learning processes that may limit the ability of an organization to look for new opportunities, continuously reinforcing existing beliefs, and making it extremely difficult for the organization to learn from other sources of experience (Holmqvist, 2003; March, 1991). The survival of an organization, however, depends not only on exploitation, but also on exploration. Exploration is about creating variety, experimenting, innovating and taking risks (Holmqvist, 2003). The tension between exploitation and exploration is, according to Crossan, Lane and White (1999), the heart of organizational learning.

The distinction in learning as behavioural (first-level) through exploitation or cognitive (higher-level) through exploration has led to the debate as to whether learning is associated with change or not (Easterby-Smith, Crossan and Nicolini, 2000). While Argote and Miron-Spektor (2011) indicate that at the core of most definitions of organizational learning is "a change in the organization as it acquires experience" (p. 1124), Fiol and Lyles (1985) indicate that learning may not necessarily be implicit in change, and change may not necessarily be the result of organizational learning. Based on their distinction of lower-level and higher-level learning they conclude that organizational changes do not necessarily imply learning but may simply illustrate the organization's ability to make small incremental adjustments in response to

environmental, structural, or goal changes. In other words, lower-level, or behavioural learning is in fact simply adaptation, while learning involves the development of insights concerning causal relationships of past actions and responses (Fiol and Lyles, 1985).

Many authors, instead of arguing whether learning is behavioural or cognitive, avoid the debate altogether by using the labels of first order (single loop, or first-level) and second order (double loop, second-level) as shorthand for more routine (exploitative) and more radical (explorative) learning (Easterby-Smith *et al.*, 2000). Organizational theories that combine change in interpretive schemas with changes in behaviour give human agency a predominate place in organizational learning, as can be seen in the re-conceptualizing of organizational routines as both a source of flexibility and a source of change central to the studies of Martha Feldman (e.g., Feldman and Pentland, 2003; Rerup and Feldman, 2011). By separating routines into two related parts, the ostensive (the abstract idea of a routine or routine in principle) and the performative (the actual performances of the routine) (Feldman and Pentland, 2003), it is possible to link improvisation and learning in the everyday performative aspect of the routine to change in the ostensive aspect and to changes in the organizational interpretive schema (Rerup and Feldman, 2011). The study by Rerup and Feldman highlights how the enactment of organizational routines on a daily basis by people throughout the organization may challenge the existing espoused schema of the organization leading to tension. This dissonance, once surfaced, may then be discussed and the required changes to the organizational schemata may be made.

Another debate within the organizational learning literature concerns the level of analysis of organizational learning. The debate centres on whether organizational learning is simply the sum of individual learning (based on error detection and correction), or if there is something more to it (Easterby-Smith *et al.*, 2000; Robinson, 2001). Argyris (1995) indicates that learning is an individual cognitive process; the individual is key to organizational learning because “it is the thinking and acting of

individual practitioners that produce learning" (p. 26). There is, however, as the author mentions a high degree of causal interdependency between individuals, groups and the organization. On the other side of the debate are those that believe that organizational learning must be something more than individual learning in an organizational context pointing to the fact that members of the organization may come and go, yet, certain behaviours, assumptions and beliefs remain over time (Hedberg, 1981). In the more recent literature on organizational learning, the debate is addressed by linking the individual, group and organizational levels of learning through dynamic processes (e.g., Crosssan *et al.*, 1999; Holmqvist, 2003). Holmqvist (2003) in his dynamic model identifies four basic assumptions in the scientific literature on organizational learning: that learning is experiential, cognitive and behavioural, involves social dynamics, and is embedded in the organization.

A dynamic model is interesting as it demonstrates how individual learning may be transformed into learning at an organizational level and satisfies Hedberg's argument that learning must occur at the organizational level if organizational behaviours, and beliefs exist after individual members move on. Other researchers have instead argued that organizational learning exists and is not necessarily due to dynamic processes of translation from the individual to the organizational level. Within this perspective of organizational learning, what an organization learns is not possessed by individual members but by the aggregate itself. To make this claim, these researchers study organizational learning from the root metaphor perspective of an organization as a culture (Cook and Yanow, 1993; Lakomski, 2001; Yanow, 2000). This stream of research conceptualizes the organization as a system of shared meaning and symbols that are expressed through objects, language and acts allowing for the argument that these cultural artifacts represent the collective 'know how' of the organization. Meanings are either reinforced or changed through interaction between organizational members and artifacts, and these activities constitute organizational learning (Cook and Yanow, 1993; Yanow, 2000).

A cultural perspective of organizational learning is not the only perspective that looks at the collective, social and interactive aspects of learning. Researchers within the stream of learning as communities of practice (e.g., Brown and Duguid, 1991; Raelin, 1997) also emphasize learning as the social construction of meanings through practice. Organizational cultural learning and communities of practice share an emphasis on groups of people acting together. While not intentional, the cultural perspective of learning of Cook and Yanow (1993) portrays a unitary, integrationist view of culture, whereby meanings are shared across the entire organization (Yanow, 2000). A 'community' view suggests a smaller unit and may allow for an easier conceptualization of many communities within a single organization (or subcultures as within a differentiation perspective of culture).

The cultural and community perspectives select an image of the organization that allows a better understanding of the nature of organizational learning, demonstrate that change does not necessarily involve learning, and focus on studying what people do and the impact of their actions on shared meanings, and less on what is going on inside of people's heads (Weick and Westley, 1996). Hence, learning may be seen as the result of human interaction; "it is embedded in relationships or relating [….] It is not an inherent property of an individual or of an organization, but rather resides in the quality and the nature of the relationship between levels of consciousness within the individual, between the individual, and between the organization and the environment" (Weick and Westley, 1996, p. 196).

Chris Argyris views organizational learning, as mentioned previously, as the accumulation of individual learning. His theories on organizational learning, and the works of Argyris and Schön on action science, indicate the importance of exposing and discussing differences in espoused theories and theories-in-use. Looking in more detail at organizational learning as defined by Argyris (1995), with particular attention to human interaction, it is possible to connect this view of organizational learning to the view of learning as a result of human interaction of Weick and Westley (1996), and to

the view of culture change as dynamic and continual, occurring as new meanings are negotiated between organizational members, and anchored in everyday action, communication and dialogue (Alvesson, 2013).

Action science (Argyris, Putnam and Smith, 1985) provides a framework that encourages the inconsistencies between underlying values, beliefs, assumptions and meanings to be surfaced, and through social interaction allows the development of new meanings, or a change in behaviours. In other words, the learning model of action science may be an appropriate framework to study organizational change from a cultural perspective. We will return to this in the next chapter.

2. SUMMARY OF THE KEY ELEMENTS OF THE THEORETICAL FRAMEWORK

The program SPCHUS clearly documents the desire for transformational change at the CHUS. The program, accepted in Phase II of Lean Healthcare by the MHSS, is based on five elements: patient trajectories, continuous improvement, balanced scorecard, transformational leadership and foundational projects creating value for patients. The finality of this transformational program, as presented earlier, is:

> De façon transversale à travers toutes les directions, améliorer les trajectoires patientes par des processus efficients, des ressources utilisées judicieusement, des personnes engagées envers leurs pratiques et des soins et services accessibles et de qualité pour les patients. Cette amélioration se traduira par une plus grande mobilisation du personnel, des gestionnaires et des médecins envers les patients.[25]

[25] Loose translation: « Improve patient pathways transversally across all departments, through process efficiencies, the judicious use of resources, and care that is accessible and safe for all patients. This improvement will result in increased engagement of all employees, managers and medical staff to meeting the needs of the patient ». This finality is documented in an unpublished document, *Programme PGM100: Déploiement du système de performance du Centre Hospitalier Universitaire de Sherbrooke. Plan Détaillé du programme.* Version 1.10, 7 Novembre 2013, p. 6

As in many other establishments, the CHUS and the CIUSSS de l'Estrie—CHUS adopted lean principles to improve the quality and safety of healthcare delivery. The adoption of lean principles in the healthcare sector, as with the adoption in the manufacturing sector, has focused on the tools and techniques. This has led to an unfortunate misunderstanding of what a lean management system is and has led to its limited potential for improving healthcare delivery.

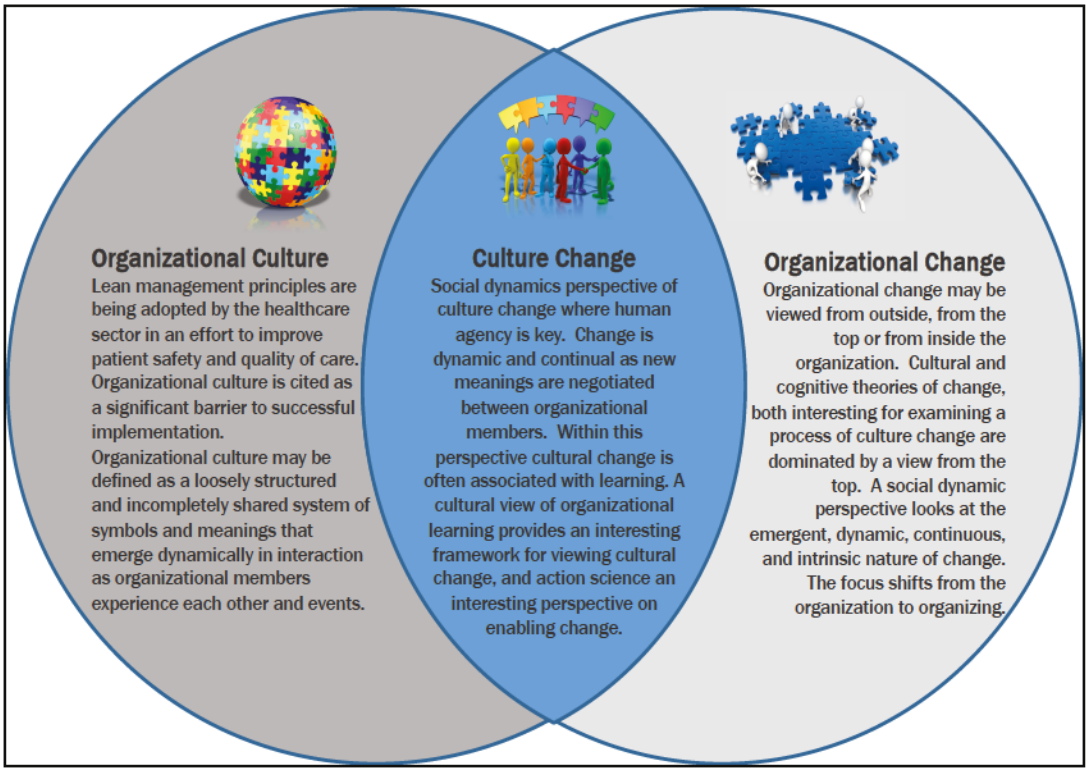
The lean philosophy, as developed by Toyota, is much more than a series of tools and techniques for improving productivity. While one of the fundamental elements of lean, continuous improvement, was somewhat successfully transferred to North American manufacturers, very few companies have achieved the success of Toyota, as we noted earlier. This may be attributed to a lack of understanding of the importance of the fundamental element of respect for people, and of the ultimate goal of creating a dynamic learning system. Adopting the fundamental elements of a lean management philosophy implicitly involves renegotiation of the network of meanings, or, in other words, a change to organizational culture, which has been identified as a significant barrier to the successful transfer management practices and principles from the private to the public sector.

In this research study, the organization is viewed as a culture (from a fragmentation perspective, where culture is defined as a loosely structured and incompletely shared system of symbols and meanings that emerge dynamically in interaction as organizational members experience each other, events, and the organization's contextual features) as was presented in the previous section. Organizational change is viewed from a social dynamics perspective, is considered to be cognitive and social, dynamic and continuous. The cultural perspective of organizational learning provides a view of learning as the result of human interaction that is embodied in cultural manifestations. This perspective provides a bridge between human cognition (beliefs, values and assumptions), normally believed to be the property of the individual mind, and external symbolic representation. Cultural

meaning is not exclusively in the mind nor the organization; it is embedded in relationships and relating. Meanings are either reinforced or changed through interaction and constitute organizational learning. While a recent study (Pakdil and Leonard, 2015) has looked at linking culture to the effectiveness of lean implementation, the process of implementation of a lean management system explored or observed through a cultural lens has not (to the researcher's knowledge) been documented in the scientific literature.

Figure 4 provides a summary of the key elements of the sensitizing concepts included in the theoretical framework that were explored given their pertinence to the managerial problem. The confrontation of these sensitizing concepts and the managerial problem guided the development of my research question.

Figure 4
Synthesis of the Theoretical Framework



Deployment of the program SPCHUS (and SGIP) is an opportunity to illustrate the implementation of an integrated performance management system based on lean principals from a cultural perspective. Active participation and reflection of those organizational members most directly involved in the deployment (senior management, middle and first line managers, and lean management system coaches) and the researcher offers an opportunity for illustrating the highs and the lows during the process of implementation, particularly when cultural transformation is desired, and to account for the role of organizational learning in this process.

3. RESEARCH QUESTION

How does a healthcare organization, trying to transform its culture, implement a lean management system?

CHAPTER THREE
OPERATIONAL FRAMEWORK

This chapter ties together the research methodology and methods, and the quality, validity and ethical considerationsshowing how and why these are appropriate given the ontological and epistemological assumptions of the researcher, the managerial problem to be resolved and the theoretical framework that informs the research.

1. RESEARCH OBJECTIVES

The research objective is to illustrate, from a cultural perspective, how a healthcare organization implements an integrated lean management system. The active participation in and observation of the implementation will provide a rich illustration of the adoption of a managerial practice from the private sector to a public healthcare organization. The cultural perspective of the illustration will hopefully contribute to bridging the gap in the scientific literature at the intersection between lean implementation and organizational culture (Pakdil and Leonard, 2015), providing insight into the way in which organizational culture may be seen as a barrier or a facilitator, how a cultural transition may be managed if an organization 'is' a culture and the role of organizational learning in culture change.

2. ONTOLOGICAL AND EPISTEMOLOGICAL ASSUMPTIONS

2.1. Research Paradigm

Philosophical assumptions are often not mentioned in research studies, despite the fact as researchers we always bring our beliefs and values to our research. They are not just tied to the development of a study but to the entire research process; they influence the managerial problem that we wish to study, the theoretical framework we choose to inform our research, the research questions we pose, the choice of methodology and methods, and the theories that we employ when analyzing and making sense of our data. Therefore, understanding our positioning allows us to make

thoughtful and reflective choices, ensures coherence and, hence, greatly influences the quality of a research study (Carter and Little, 2007; Creswell, 2013; Robson, 2011).

A researcher's interpretive framework or paradigm, defined as a "loose collection of logically related assumptions, concepts or propositions that orient thinking and research" (Cohen and Mannion 1994, p. 38; cited by Mackenzie and Knipe, 2006, p. 2), is something very personal drawn from experience and fundamental beliefs. This personal framework may find resonance in one of the definitions or classifications in the scientific literature or it may not. In my case, it does not entirely. My interpretive framework lies in the postmodern philosophical tradition of Chia (2003), somewhere between the research paradigms of pragmatism and postmodernism. To understand this positioning, it is first necessary to explain the distinction between a philosophy of science and a paradigm. According to Bechara and Van de Ven (2011), both are concerned with ontological, epistemological and methodological assumptions, however, a philosophy of science applies broadly to all fields of scientific inquiry while a paradigm provides a more concrete set of assumptions that apply to a specific field of study. As an example, positivism is considered a philosophy of science, while functionalism would be considered a paradigm normally associated with the field of social sciences (*Ibid)*. Following this thinking, Tsoukas and Chia (2011) describe scientific philosophies as dealing with higher order or meta questions, questions that are generated from outside the frameworks used for carrying out research; they answer questions about the research frameworks used for generating organization theories. These authors define two philosophical traditions of science: modernism and postmodernism.

I identify with the postmodern philosophical tradition, believing that reality is considered indeterminate and incessantly changing (becoming versus being, per Chia [2003]); it is virtual and shaped over time by the interaction of groups, and their social, cultural, and political values (historical realism). It is difficult to convey the ever-changing nature of reality with language, nevertheless, the theories we develop help us

to negotiate our way in the world, even if they don't adequately describe the specific goings-on of any situation. In addition, I adhere to the necessity to reflexively question the underlying values and forces that shape the way we think and act in organizations, and to the use of reflexivity to guide our actions.

In terms of my interpretive framework, as mentioned, I consider it to be a combination of postmodern and pragmatist. Postmodernism, as a research paradigm is highly fragmented. Hatch and Cunliffe (2009) indicate that postmodernism may be distinguished from the other paradigms by its refusal to search out Truth. (In this sense, there is similarity with the pragmatist paradigm.) While this is true of all factions of postmodernism, postmodernists appear to oscillate between a variety of different philosophical assumptions (*Ibid*). Many view the postmodernist perspective as cynical or nihilistic, considered as having a critical edge "rejecting the human agent as the centre of rational control and understanding." (Cooper and Burrell, 1988, p. 91.) In other words, postmodernism is often thought as having a political stance to it, seeking to critically expose the nature and function of organizations (Bechara and Van de Ven, 2011). There are, however, more 'neutral' advocates of postmodernism that emphasize instead the inadequacies of language in capturing the entire realm of what we tacitly know and understand. This 'neutral' position of postmodernism emphasizes the fragile, processual and discursively constructed nature of social phenomena (Alvesson and Deetz, 2006).

The four main themes of the interpretive framework of pragmatism according to Elkjaer and Simpson (2011) include: experience (viewed not as purely subjective as in constructionism, but as shared and objective as well as personal and subjective, constituted by events that emerge in the present out of the continuity of social actions); inquiry (based on the scientific method of plan-do-study-act where studying involves reflexive thinking concerning social actions anchored in everyday situations); habit (acquired dispositions to respond in certain ways in certain conditions are not rigid and flexible but constantly emerging and changing over time); and transaction (which refers

to a social self that is continuously in the making through interaction between the self and the situation; through interaction individuals both shape and are shaped in any given social situation). The authors very succinctly resume "the interplay between these themes informs a temporal view of social practice in which selves and situations are continuously constructed and reconstructed through experimental and reflexive processes of social practice" (*Ibid.*, p. 55).

Combining this view of pragmatism, and the more neutral interpretation of postmodernism grounded in the philosophical assumptions of Chia (2003), leads to my postmodern pragmatist positioning which acknowledges both structure and agency without favouring one over the other. The themes blur the distinction between individual and organizational levels of analysis, and between knowledge and action. A postmodern pragmatist believes that events and objects do not have a true 'essence,' from which it follows that they do not believe it possible to 'truly' represent or measure them. Most importantly, generating theories that 'get it right' is not the central interest; the concern is in the consequences of the application of these theories and their usefulness in guiding action that leads to the desired results (Cherryholmes, 1994). Looking to the consequences of actions leads one to the key values of tolerance and democracy (Cherryholmes, 1994). As there is an infinite number of meanings that may be assigned to a social situation, the use of democratic dialogue to review and assess as wide a range of meanings and consequences as possible, ensures that the consequences are holistically examined, and actions are not biased, dictated, or imposed.

Given my dominant positioning as a postmodern pragmatist, and the nature of the research question, this will be the interpretive framework for this study.

2.2. Researcher's Positioning

A postmodern pragmatist researcher interacts directly with research participants. Contrary to a modernist/positivist perspective of the researcher as an

objective observer investigating and understanding a reality that exists outside of individual consciousness, the researcher within a postmodern pragmatist paradigm interacts directly with research participants, introducing reflexive practices that will guide action, and generate knowledge.

The researcher's position, within this approach to research, is that of a reflexive participant in change making.

3. METHODOLOGICAL CONSIDERATIONS

3.1. Research methodology

Mackenzie and Knipe (2006) define research methodology as the overall approach to research linked to the theoretical framework. As mentioned in the discussion on organizational learning in Chapter 2, the learning model of action science is an appropriate framework for studying organizational change from a cultural perspective. The organizations involved in this study have described the desired change as transformational, as touching all aspects of the organization, and as a change in 'the way things are done' to improve the quality of healthcare provided. A lean management system has been chosen as the vehicle of change, which is rooted in very different assumptions than traditional management theories and, hence, requires very different management practices. Action science is a specific form of action research, and its distinction from other forms will be discussed shortly. Action research, in general, embodies "the powerful notion that human systems can only be understood and changed if one involves the members of the system in the inquiry process itself" (Coghlan, 2011, p. 58). It implies that three elements are necessarily present in the research: action, research and participation (Greenwood and Levin, 2007).

The origins of this methodology are extremely diverse. Many authors trace its origins back to Kurt Lewin (e.g. Coghlan, 2011; Reason and Bradbury, 2001/2006; Roy and Prévost, 2013) and the tradition of Organizational Development. The action research practiced by Lewin was comprised of change experiments on real problems in

real settings, involved iterative cycles, challenged the status quo, and contributed to knowledge and social action whereby the resulting change typically involved re-education (Argyris *et al.*, 1985). Since its foundation as a research methodology within the modernist philosophical tradition, it has continued to evolve under the influence of many other philosophies and theories. The Marxist dictum (radical humanism) that the important thing is not to understand the world but to change it (Reason and Bradbury, 2001/2006), has greatly influenced more contemporary forms of action research where emancipation and liberty are the primary goals. Influences from social constructionism, general systems theory, complexity theories, and pragmatism (Coghlan, 2011; Eikeland, 2012; Reason and Bradbury, 2001/2006; Roy and Prévost, 2013) have led to the variety of different forms of action research that exist today, which include: action science, action learning, participatory action research, critical action research, action inquiry and pragmatic action research.

Two forms of action research are of interest for this study; action learning and action science. While similar there are nuances that are important to understand as it is the basis for the logic of the methods and analysis used in this study.

Action learning, like all forms of action research, is based on the notion that people learn most effectively when resolving real life issues. The focus of action learning is behavioural change based on reflection of work practices (Raelin, 1997). Action science, on the other hand, takes this idea further and encourages dialogue about fundamental beliefs and implicit values. By making explicit these theories-in-use, it is possible to identify inconsistencies between current actions and the new desired practices, and in so doing encourages organizational learning (Bates, 2000; Baron and Baron, 2015; Herr and Anderson, 2005; Raelin, 1997). Action Science, introduced by Argyris *et al.* (1985) includes elements of critical theory in their interpretation of action research indicating that research should engage humans in social reflection to change their world. The authors' use of the word 'science' is intentional given their viewpoint that action research had lost its scientific edge, focusing on problem solving to the

detriment of theory building and the generation of scientific knowledge (Coghlan, 2011; Herr and Anderson, 2005). Friedman and Rogers (2008) do not consider action science as a distinct method but as a set of conceptual and practical tools that can be incorporated in action research, which may be defined as follows.

> […] action research is a participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview […]. It seeks to bring together action, reflection, theory and practice, in participation with others, in the pursuit of practical solutions of pressing concern to people, and more generally the flourishing of individual persons and their communities (Reason and Bradbury, 2001/2006, p. 1).

This present study adopts the definition of action research of Reason and Bradbury (2001/2006) and incorporates the conceptual and practical tools of action learning and action science with the intention of providing a rich, detailed description of the process of change, and comparing these findings to scientific literature on lean transformations, organizational culture change and organizational learning.

3.2. Research Methods and Logic

The research methods and logic refer to the procedures and tools that were used for the collection and analysis of data (Mackenzie and Knipe, 2006). The primary purpose of action research is to better understand change. It is a cyclical process incorporating successive loops of observation-analysis-action-observation-reflection, which terminate when the participants feel that the original problematic situation has been resolved and/or potential learnings achieved (Roy and Prévost, 2013). During this process, the researcher moves constantly between action and critical reflection, providing feedback to the participating organizational members continuously throughout the research (Dick, 2002).

Prior to successive loops, the action research began with a diagnostic of the problem to be resolved. As explained in Chapter 2, the data used to generate the diagnostic of the problem to be studied was made from observations and interviews

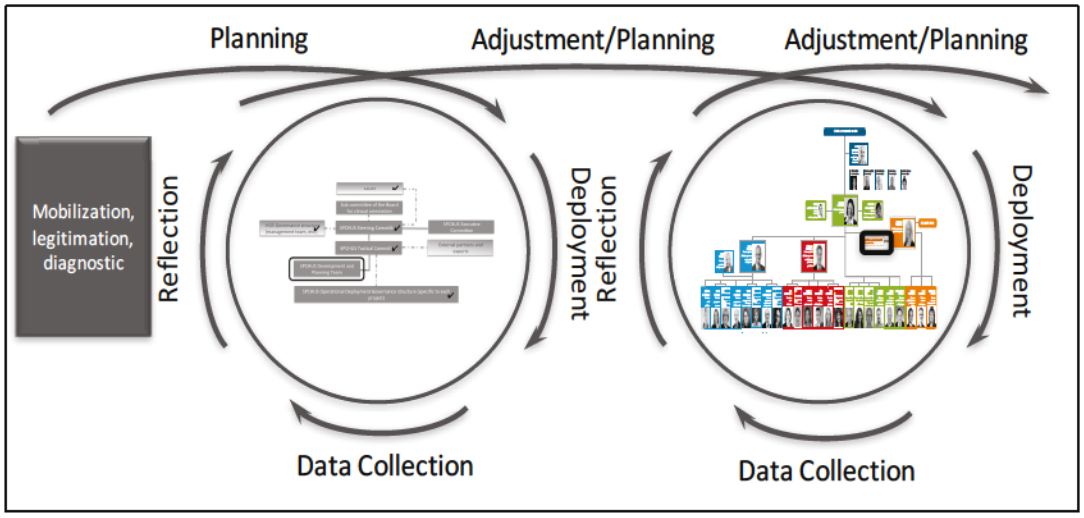
with the CHUS from January to August 2014. The diagnostic was fed back to members of the Development and Planning Team to ensure that the problem representation was sufficiently shared (Roy and Prévost, 2013). As previously described, the problem facing the Quebec healthcare establishment is how to implement an integrated management system embodying a lean philosophy in such a way as to fundamentally change the way in which 'things are done' at all levels of the organization, leading to desired performance improvements in the delivery of care.

The participating organization for this action research study was chosen as it was seen by the healthcare network as a model organization in terms of its use of the various lean methodologies, and its progressive thinking on moving past the tools and techniques to a more philosophical view of lean. It was also chosen given its expressed desire to fundamentally transform the organization through the implementation of a lean management system. With the healthcare reform introduced in April of 2015, it was natural that the action research study continued when the CHUS became part of the integrated health center CIUSSS de l'Estrie – CHUS. In addition, several senior members of the newly formed organization had publicly stated their support of the reform, and the belief that the reform, along with the application of lean principles, would help them transform the efficiency and effectiveness of healthcare delivery. These conditions were ideal for an action research study: the participants wished to succeed in making major changes and were, therefore, open to instigating and learning from change; and when the turbulence was introduced with the introduction of reform they were convinced that it was aligned with their desired change and would be positive for the organization. These seemed excellent conditions to generate learnings that would hopefully allow the organization to succeed in its quest.

The action research process, visually presented in Figure 5 covers two cycles of action research; the introduction of a management system at the CHUS as a participant in the second phase of Lean financed by the MHSS, and the conception and introduction of a management system at the CIUSSS de l'Estrie— CHUS. It also

includes the turbulent period during the adoption of Bill 10 into law and reorganization of the healthcare sector into 34 healthcare establishments. Several of the participants of the first cycle continued on in the second cycle, while several new participants joined with the creation of the CIUSSS de l'Estrie — CHUS. The learnings from the first cycle were transferred to the participants of the second by those that were involved in both cycles. Figure 5 summarizes the action research process. Note that the image presented on the interior of each action research cycle for illustration purposes only and represents the change in the project teams following the implementation of the reform. The object of analysis (the implementation of an integrated performance management system) remained the same.

Figure 5
Action Research Process



The researcher's positionality, given the ontological and epistemological assumptions, was discussed in section 2.2. A more precise definition of this positionality, based on a continuum developed for action research by Herr and Anderson (2005) is one of an outsider in collaboration with insiders. While I had very little first-hand knowledge of the healthcare network, I did have a great deal of experience with the implementation and use of a lean management system. The managerial problem was circumscribed by the researcher (and validated by organizational members), and the organization was interested in learning about cultural change from the process of implementation of an integrated management system. The mode of participation with the organizational members may be considered one of co-learning (Herr and Anderson, 2005). The researcher and the organizational members shared knowledge to create new understandings and worked together to determine the appropriate action plans. The researcher was not responsible for the process but facilitated the process by providing insight from previous experience, and feedback from observations and analysis.

It should be noted, however, that positionality in action research is complex and ever-changing. At the beginning of the research, the researcher was clearly an outsider.

During the first few months of intensive work with the Development and Planning Team, the researcher's involvement was primarily one of observing to understand the organization, and one of providing information and examples concerning certain concepts of lean management and organizational culture, both from the scientific literature and from personal experience. Over the three years of the study, this shifted to a position of outsider-within whereby the researcher had a somewhat unique vantage point. As more and more information was gathered through participation observation at various levels of the organization (which was unique as those participants most deeply involved in designing and deploying the change effort did not have this opportunity) the role shifted to a much more participative role, particularly at the tactical level of the organization. Given the unique positioning within the organization, the researcher took on a facilitative role, reflecting back to the organization the critical events, clarifying principles of lean management, and asking questions that permitted reflection and learning essential to action research.

Critical reflection throughout the research process concerned not only the data and its interpretation but also the methodology and methods. The shift in positioning of the researcher led to several learnings on the action research process that will be addressed in the analysis in Chapter 4.

Data was collected over approximately three years (January 2014 to January 2017). Data collection methods included semi-structured interviews, informal individual meetings, group discussions, participant observation, institutional document analysis, memo writing and a reflexive research journal. In addition, all interaction with the research site was documented in a record log maintained throughout the research period.

In total, the researcher spent a total of 1141 hours interacting with various members of the organizations; 64 hours of semi-structured interviews, 69 hours of individual meetings, 713 hours of formal participant observation, and 428 hours of

informal participant observation. This interaction and observation generated over 1600 pages of field notes, and approximately 950 pages of verbatim transcriptions. In addition, numerous reflexive memos were created, and secondary documents such as internal and external communications were reviewed and analyzed. Appendix C provides a summary of the field research data collected and the institutional documentation consulted over the course of the study.

In total 64 interviews were conducted. The first set of interviews provided information on the managerial problem as seen by the participants and were conducted in October and November 2014. The second set, concerning the key learnings from the first cycle of action research, was conducted from February to March 2015. The third set of interviews conducted at the request of the organization to monitor the level of understanding of senior organizational members of patient trajectories and of SGIP, were carried out in early September 2015. The fourth set of interviews, completed in March and April 2016, focused on research participants' interpretation of SGIP. The final interviews were conducted in October and November 2016 to complete the key learnings of the second cycle of action research. Table 5 summarizes these interviews, and the interview guides may be found in Appendix D. Note that the interview guides were used flexibly by the researcher. This approach allowed the interviewer to adjust questions when other areas of interest emerged (Barson, Doolan-Noble, Gray and Gauld, 2017; Lejeune, 2014).

Table 5
Summary of Semi-Structured Interviews

Interview Purpose	Number	Average length	Hierarchal Position
Circumscribe the Managerial Problem	5	0:45:11	Executive Director (1) Director (2) Manager (2)
Learnings 1st Cycle	9*	0:54:51	Director (3) Senior Manager (1) Manager (1) Professionals (4)

Understanding of Patient Trajectories and SGIP	18	0:50:57	Executive Director (4) Director (14)
Understanding of SGIP by Steering Team Members	11	0:49:57	Executive Director (4) Director (6) Senior Manager (1)
Learning 2nd Cycle	21*	0:56:06	Executive Director (4) Director (6) Senior Manager (2) Manager (5) Professional (4)

* A group discussion was also held with the participants of the tactical level teams responsible for the conception and deployment of the integrated management system to discuss the learnings of the two action research cycles.

Formal participant observation occurred during all meetings of the committees of the governance structure of both SPCHUS and SGIP as well as during deployment in the three pilots at the CHUS, and the four pilots at the CIUSSS de l'Estrie — CHUS. In these cases, the researcher actively participated in discussions concerning the implementation of the lean management system and decisions on the deployment plan based on progress. It is important to note, however, that the organizational leaders were the final decision makers throughout the entire implementation. In addition, the researcher was an observer/participant[26] in management forums, training activities, management activities such as gemba walks, daily caucuses in various sectors, A3 committee meetings and departmental meetings. Informal observation occurred during the time that I spent working from the office provided at the establishment, and includes informal hallway, lunch or coffee break discussions with organizational members during this time as well as attendance at social activities or conferences with members of the organization. All observations were noted in field journals. The field journals also included notes on the methodology, my reactions to various elements, ideas on theoretical concepts to explore, and further questions to ask. The field journals were, hence, also my reflexive journals for the entire period of the study.

[26] The role in these meetings was primarily one of observation; however, in some instances (for example the strategic planning session, or hoshin kanri exercise, in June 2016, the researcher facilitated part of the process. In other instances, the researcher provided summaries of some of the data collected during the research process to stimulate discussion and reflection.

The analysis and reflection stages of each cycle were open and evolving. As the participants reflected on the learnings from the first action stage, emerging patterns and theories were compared to existing theories. The literature drawn on for the study developed further as the researcher and co-researchers gained a deeper understanding of the issues related to the deployment of the management system. This literature included organizational identity formation and definitions of integrated management systems. Interpretation of these theoretical concepts, and their relation to the introduction of a lean management system were fed back to participants during the action research cycles (Herr and Anderson, 2005). Both cycles were characteristic of action learning. The research was data driven; the real-life situation that the participants faced each day guided the research and subsequent actions (Dick, 2002).

The tools of action science were important following the second action learning cycle. The theoretical concepts of organizational learning, organizational culture, public sector reform and the role of leadership in this type of change were referenced, meanings and interpretations of organizational members were made explicit providing a window for participants to take a step back, reflect on beliefs, values and meanings in order to make the inferential leaps between the data and conclusions (Raelin, 1997a).

3.3. Data Analysis Techniques

Qualitative data analysis has been described as messy (Klag and Langley, 2013). Getting from the pages and pages of raw data (field journals, interview transcriptions, organizational documents and analytic memos) to a theoretical contribution to the scientific literature and a practical contribution to the organization was a complex and arduous task.

The analysis strategy chosen for this research is eloquently described by Heracleaous (2001) as a “hermeneutic, iterative process of going back and forth from critical reflection to the data, and from the part to the whole, searching for key themes and patterns, and questioning, redefining or buttressing the key themes and patterns

identified with further evidence." (p. 431). Throughout this process, reading, thinking and writing were the key analysis tools, as these are central to interpretation (Geertz, 1973). This mode of writing analysis, as documented by Paillé and Mucchielli (2012), and the qualitative analysis techniques of Lejeune (2014) greatly influenced the data analysis of this research.

The initial attempt to make sense of the data was to document in detail what was happening in the organization throughout each of the action cycles and generate the narrative of the process. The goal was to provide a holistic view of the data that provides temporal information of 'what went on' during the study (Maxwell, 2013). This narrative was constructed from the field journal entries, from the interviews and from a review of secondary documentation. The narrative focuses on the contextual details, and the process of change resulting from the design and deployment of an integrated management system. To ensure that the narrative reflected the participants' experience, it was fed back (in the form of a PowerPoint presentations) to the tactical teams responsible for the conception and introduction of the integrated management systems. Both teams validated that the narrative represented their experience, and any suggested modifications, agreed upon during the group discussions, were included in the final narrative found in Chapter 4.

From the descriptive narrative, the analysis moved from a description of 'what went on' to what could be learned concerning the introduction of a lean management system. To get to the key learnings, individual interviews were transcribed and annotated, and the emerging themes were documented (NVivo version 11 was used). In addition, notes and observations from field journals were also reviewed, as was secondary documentation provided by the organizations. Ideas and thoughts, as well as further avenues to explore were noted in memos and the developing themes were fed back to the participants and further refined. These learnings provided insight for planning the next steps in the introduction of the system.

The learnings of the second cycle of action research was organized around the principles of combating chaos and building a foundation for everyday excellence described in the book *The Outstanding Organization* by Karen Martin. This framework was chosen by the research participants (organizational members) as the language was adopted by Senior Management during the implementation of the management system. More details on the framework are provided in the narrative of Chapter 4.

The analysis of the introduction of a lean management system across the two action research cycles was conducted around the framework of MacKenzie and Hall's (2015) briefing discussed in Chapter 2. Their framework, describing three levels of lean transformation, proved useful in illustrating the lean journey of the organizations participating in this study.

Throughout the research cycles, an understanding of what was going on in terms of culture change evolved. Of particular importance to the analysis was the use of memos, providing a paper trail of reflections on emerging themes, relationships between findings and theoretical constructs, and on potential thematic categories. These memos ensured systematic reflection throughout the action research. The final analysis, therefore, consisted of moving from the learnings on the introduction of a lean management, to an analysis of the implementation from a cultural perspective. Again, the basis for this analysis was the raw data and the memos written throughout the research, however, this analysis was concerned with meanings and interpretations and how these evolved over the course of the study. Hatch's (1993) dynamic model of culture, introduced in Chapter 2, was the basis for this analysis.

It is important to note that the analysis was a continuous process, and not one that may be precisely broken down into specific stages. The researcher cycled continuously between understanding the process of implementation to viewing the change from a cultural perspective, and from the observations to reflection to action. To facilitate the documentation of the results, however, these elements are presented in different sections.

3.4. Summary of the Methodological Orientations of the Research

Before turning attention towards the quality, validity and ethical considerations of the research, a summary of the methodological orientations will be provided. This research is based on postmodern philosophical assumptions and a contemporary pragmatist paradigm. As discussed previously, the central interest of researchers sharing this interpretive framework is the application of theories and their usefulness in guiding action that leads to desired results (Cherryholmes, 1994). The research methodology is action research, specifically using the tools of action learning and action science to understand the process of adopting an integrated lean management system. Data collection methods included participant observation, semi-structured interviews, group discussions, informal observation, and secondary document review. Reflexive memo writing was the preferred technique for data analysis. Reflexive memos were used to: generate the description of the events as they were occurring (descriptive memo); reflect on the theoretical concepts that were explored throughout the research (theoretical memos); determine the next steps in data collection required based on the progression of the research and theoretical findings (methodological memos); and finally to move from the coding of interviews and group discussions to the documentation of the key learnings and the final analysis (analytical memos) (Lejeune, 2014). These orientations provided the information necessary to recount the spiraling change in the researchers and participants understanding of what was happening in the organizations (French, 2009; Herr and Anderson, 2005). Table 6 provides a summary of the methodological orientations of this research.

Table 6
Summary of the Methodological Orientations of the Research

Philosophical Tradition and Research Paradigm	Postmodern pragmatism, acknowledging: both structure and agency; the blurred distinction between individual and organizational levels of analysis; proximity of knowledge to action; importance of generating theories that are useful in guiding action.

Research Methodology	Action Research, using the tools and practices of action learning and action science.
Research Methods	Semi-structured interviewing, group discussions, participant and non-participant observation, secondary document analysis
Data Analysis Techniques	Writing mode analysis through memos (descriptive, theoretical, methodological and analytical)

Adapted from Heracleous, 2001

3.5. Quality, Validity and Ethical Considerations

It is important when assessing the rigour of a research study to use criteria that are appropriate for the methodology (Dick, 2002). Four important factors are suggested to judge the quality of action research: the robustness of the initial diagnostic, the degree and quality of cooperation and collaboration between the outside researcher and participant co-researchers embedded in the context, the rigour of the action research process (quality of the action reflection cycles) leading to change and new knowledge; and the development of competencies outside of the research itself (Coghlan, 2011). Eden and Huxham (1996), propose twelve elements that indicate action research is of good quality. The elements identified by these authors may be summarized as the need for intentionality of the research to initiate change that is useful to an organization; the explicit aim to transcend the specific and make a theoretical contribution to knowledge; a requirement for a high degree of method and orderliness in the reflection stages; the necessary use of triangulation as a dialectal device for the development of theory; the use of theory to guide subsequent actions and the importance of understanding and clearly identifying crucial variables from the history and context of the intervention necessary to demonstrate the validity and transferability of the research.

The framework for evaluating the quality of qualitative research proposed by Miles, Huberman and Saldana (2014) is also pertinent for this study, however, some attention is required as many of the quality criteria proposed in qualitative research is based on finding equivalents for criteria used in quantitative studies. The criteria from within action research, and from a postmodern pragmatist interpretive framework, are quite different. It is important in documenting the findings of this type of research that

the process is repeatable; not to demonstrate that a different researcher would find the same things but demonstrate the robustness of the process by which conclusions were arrived at.

The elements that are important for action research are presented within the five main categories of the Miles *et al.* (2014) framework. Note that the first category of these authors is Objectivity/Confirmability whereby it is indicated that the research be as explicit and self-aware as possible about unacknowledged personal beliefs, values and assumptions and how they may have come into play in the research. Obviously, the progress of the research was influenced by the philosophical perspective, the professional experience and the interests of the researcher. I prefer to consider this influence not as bias but "oriented data collection" to use the words of Christophe Lejeune (2014). Given the positioning, experience and interests, combined with the managerial problem and the research question, the researcher oriented the data collection and analysis to understanding the lean transformation from a cultural perspective. The data collection methods (interviews, observation, secondary documentation review) and triangulation of these, combined with the use of a reflexive journal, validation meetings with colleagues that were not involved in the research project, and validation of the narratives by participants ensure that the conclusions of the study do not simply reflect the experience of the researcher, but instead the participants' experience and learnings (Herr and Anderson, 2005).

For enhanced Reliability/Dependability/Auditability, it is recommended that the researcher's role and status within the site be made explicit. Action researchers are often confronted with tension between a perception of their role as a consultant, with the expertise necessary to solve a problem, and their role as a participant researcher, generating knowledge from the interpretation of changes underway within the organization. The introduction of the researcher at the site by organizational members with clear explanation of the expected role at the outset of the project was an important factor. Clarification of this role throughout the project was necessary to remind the

researcher and the co-participants of the importance of the clarity of this role to the reliability of the research. Another key element for auditability was to specify the theoretical constructs used at the initial stage of research and during the subsequent cycles of reflection and action planning.

To ensure Internal Validity/Credibility/Authenticity multi-angulation between the various data sources, the validation of participants that the conclusions were considered accurate, and a rich and meaningful description of the context were elements that were considered. This last element was also used as the primary element for ensuring the External Validity/Transferability of the research outcome. Enough information will be provided in the next chapter to allow readers to judge the transferability of research findings to their own context and problem. The Utilization/Application of the research is the driving force behind the choice of the action research methodological approach and was evaluated in real time throughout the research project. Reflection on actions taken throughout the cycles until the co-researchers felt that they had learned enough to continue with the adoption of an integrated lean management system to achieve the desired transformation.

Table 7 provides a synthesis of the quality criteria proposed by the authors cited above and how they were integrated to ensure the quality of the research study.

Table 7
Quality Criteria and Tactics

Criteria	Strategy for Action Research	Tactics for the current study
Objectivity/Confirmability	The rigour of the action research process. The sequence of data collection, processing and transformation is clearly explained. Conclusions are linked with exhibits of the data collected.	Use of a reflexive journal by the researcher, and explanation to participants of the process. Validation meetings with colleagues outside of the project to support continuous self-reflection. Validation of the narratives by research participants (co-researchers).
Reliability/Dependability / Auditability	Legitimacy of the researcher's role within the organization. Robustness of the original diagnostic (managerial problem). Explicitness of the choices made during the action research process. Use of theory to guide subsequent actions.	Researcher's role and status within the establishment explicitly stated at the introductory phase of the research, and throughout the action research cycles. Validation of the description of the managerial problem by co-researchers within the organization. Documentation in research journal and reflexive memos of choices made, and the theoretical constructs used to inform each of the action research cycles.
Internal Validity/Credibility/Authenticity	Degree and quality of cooperation and collaboration with the co-researchers embedded in the context. Degree of method and orderliness in the reflection stages. Resonance with the co-researchers concerning the reflection cycles.	Multi-angulation of data sources (field observation notes, documentation review, semi-structured interviews, group discussions and reflection cycles). Validation by co-researchers of the context description and the findings of the research.
External Validity/Transferability/Fittingness	Identification of crucial elements within the context and history of the organization. Transcend the specific and make a theoretical contribution to the scientific literature.	Rich description of the context generated from document review, field notes and interviews. Comparison of findings to existing theory.

Utilization/Application/Action Orientation	Intentionality of the research to initiate change useful to the organization. Development of competencies outside of the research itself.	Continuation of action research cycles until the co-researchers believe that the problematic has been adequately resolved. Reflection and documentation of learnings of a larger scope than the problem itself

Adapted from Coghlan (2011); Eden and Huxham (1996); Herr and Anderson (2005); Miles *et al.* (2014)

Action research is a single case, and as such often provokes questions concerning external validity (Tsoukas, 2009). In this case, we are trying to illustrate in detail what is going on during the process of implementation of a lean management system from a cultural perspective. The results of the analysis were used to refine general concepts that may be found in the scientific literature. Reflection and analysis on the learnings of the implementation in a healthcare organization attempting to transform its culture may help in understanding in more detail larger concepts concerning lean implementations, organizational culture and culture change. In addition, within this three-year longitudinal action research study, a multitude of temporal observations have been considered and interpreted, leading to a rich portrait of the dynamic process of implementation.

Action research also raises questions on how it can "transcend the single case without losing the action element along the way" (Gustavsen, 2003, p. 95). In this research study the action is focused around the implementation of a lean management system in a healthcare establishment. The learnings generated by the participants concerned what worked well, what did not work, and what adjustments could be made in the introduction plan to better replicate the principles and philosophy of lean management. These are the action elements of the research. What transcends this case, and answers the research objectives, are what the action, the difficulties, the successes, the learnings, and the adjustments tell us about organizational culture and organizational learning.

3.6. Ethical Considerations

Ethical considerations in action research are more complex than in other research methodologies. In action research, decisions are made jointly between participants that have voluntarily decided to work in partnership with the researcher to resolve a managerial problem, and to create knowledge from the changes introduced. The application of the guiding principles of action research ensured that participants were treated with respect throughout the project (Roy and Prévost, 2013). In the most general terms, ethical conduct in action research relies on the integrity of the researcher. The researcher was considerate and respectful of the democratic choices made by the research team, ensured that all participants in the project did so voluntarily, protected the confidentiality and anonymity of participants if so desired (explaining the limits of this within action research), reported truthfully on the research process and findings, and ensured that the work and ideas were credited to the rightful owners (not only in the current research, but also in any future publications).

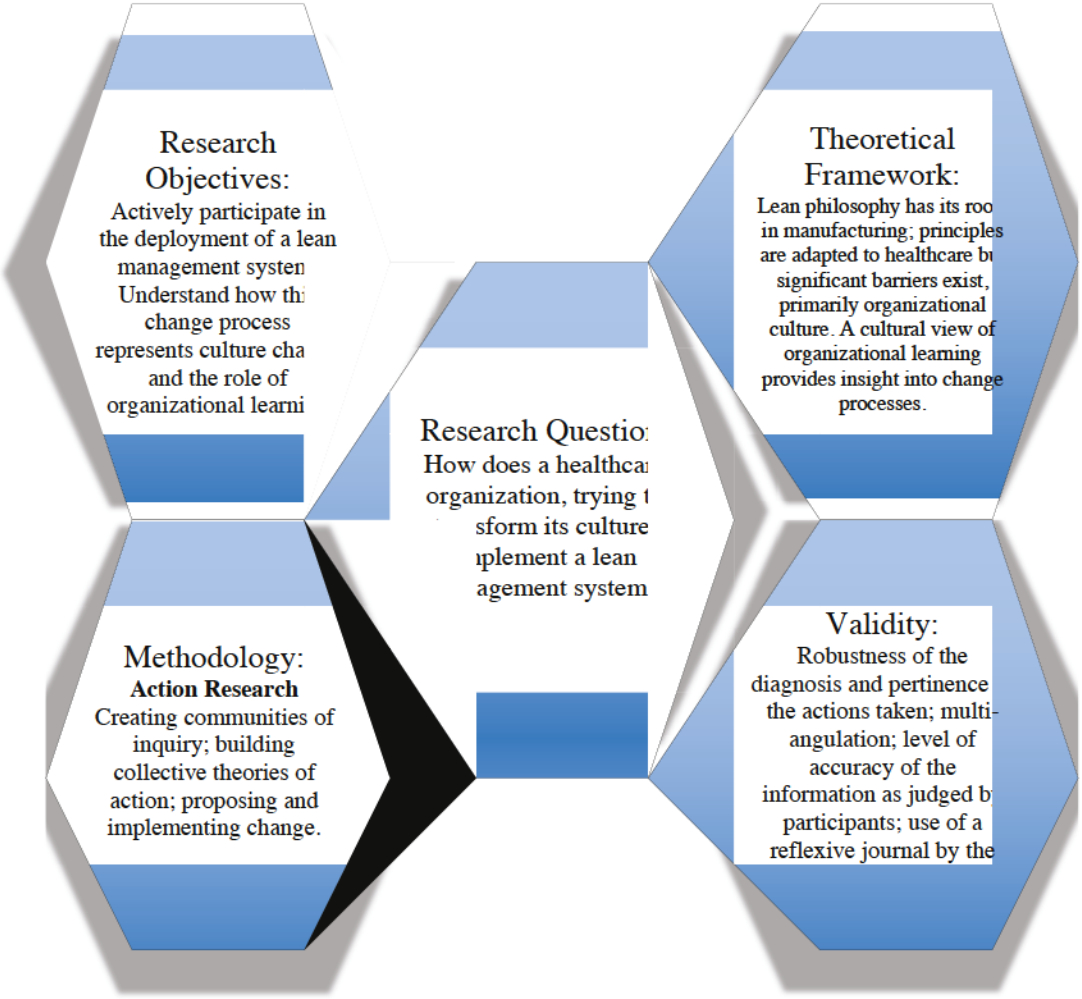
The consent forms for both the individual interviews and the group discussions are included in Appendix E. All participants were informed of the objectives of the research and the advantages and disadvantages of participating. All of the participants freely signed the consent forms prior to interviews and group discussions. At any time during the research, the participants were free to indicate that they wished to withdraw from the study, at which point any individual electronic recordings and transcriptions would be destroyed, and none of the observations directly related to the individual would be used in the study. If the participant had taken part in a group discussion, the recording would not be destroyed, however, individual comments made would not be used. As the research participants were members of organizational governance structure, withdrawing from the study did not mean that they could withdraw from the committee meetings. Participation at the committee meetings was under the authority of the organization. None of the participants withdrew over the three-year period of the study.

The research project was submitted and approved by the ethics committees both at the University of Sherbrooke, and the CHUS. Annual renewals were obtained over the period of the research.

4. SUMMARY OF CONCEPTUAL FRAMEWORK

As mentioned previously, the conceptual framework (according to the definition of Ravitch and Riggan [2012]) provides the argument of why the research study is important and why the study methods may be considered appropriate and rigorous. I have chosen to represent the conceptual framework of my dissertation using Maxwell's (2013) interactive model of qualitative research. The framework is constructed from research objectives grounded in the managerial problem and the confrontation of the problematic and the theory leading to the research question. The methodology is derived and coherent with the research objectives and research question, and validity considered in light of the methodology, existing scientific literature and criteria appropriate to the methodology. Figure 6 synthesizes the conceptual framework for my dissertation. The content is informed by Coghlan (2011) and Friedman and Rogers (2008).

Figure 6
Synthesis of the Conceptual Framework for this Study



CHAPTER FOUR
RESULTS AND ANALYSIS

This chapter presents the results and analysis of the three-year longitudinal study. To begin, a summary of events over the two action learning cycles is provided. The summary is presented chronologically as it allows readers to immerse themselves in the organization and experience the events as they unfolded during the implementation of an integrated management system. Choosing this method of organizing the information may be confusing to the reader as the description jumps from events happening outside, to events that are happening at various hierarchal levels of the organization. To facilitate understanding, Figure 7 provides a visual and chronological account of the decisions, actions and events that occurred over the three-year period of the study, and which are explained in more detail in the narrative. The elements that are noted as critical were identified by research participants as influential in the implementation of an integrated management system. Also noted are the activities of the researcher, providing the involvement of the researcher in the organization over the course of the study in a visual manner.

The description of each action research cycle commences with the narrative of the process of development and implementation of the system documenting the preparation for action, the actions taken, and decisions made, and finishes with an account of the key learnings from the perspective of the participants. A synthesis of the learnings from both cycles is then presented, providing additional insight into the lean transformation over the period of the study. Following this, the analysis turns to a cultural analysis of the adoption of a lean management system.

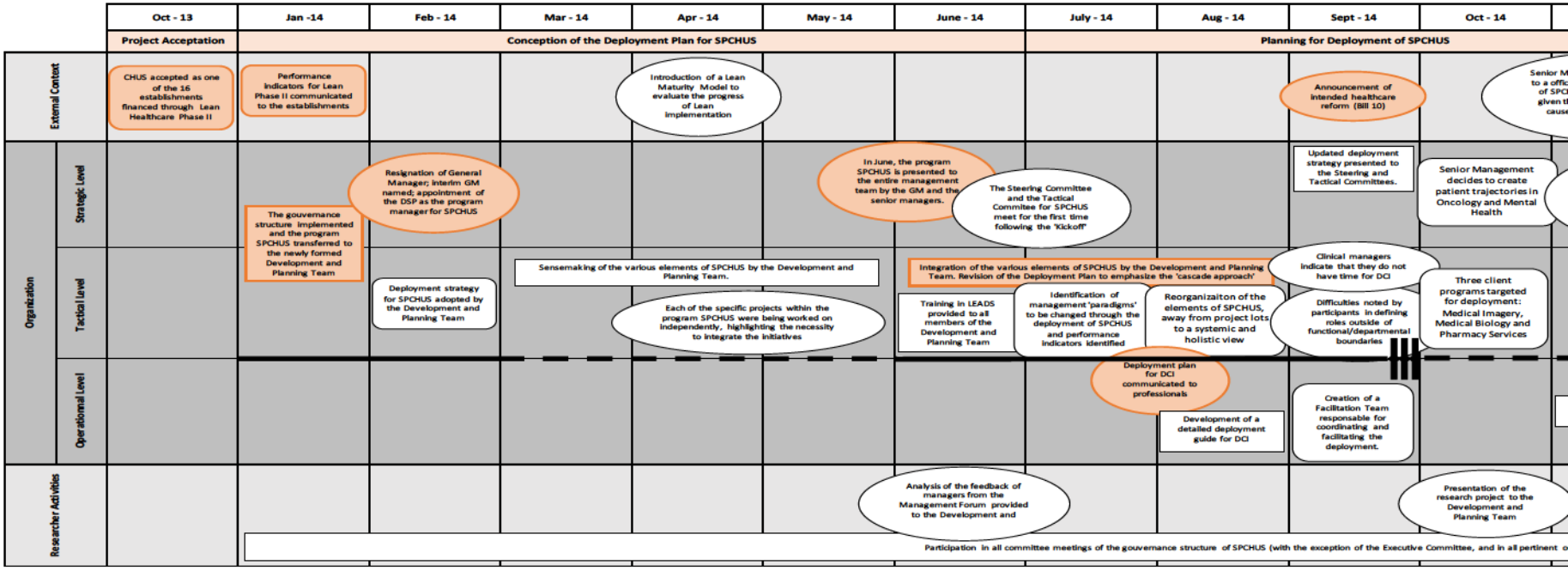
1. CHRONOLOGICAL NARRATIVE OF THE IMPLEMENTATION PROCESS

The narrative is told principally through the eyes of research participants at the tactical level in each of the organizations. Interviews and observations do span the strategic and operational levels to varying degrees, providing a more holistic perspective of what was going on within the organization concerning the adoption of

an integrated management system based on a lean philosophy. As the integrated management system was not created in isolation from the external environment, the narrative also references, on certain occasions, what was happening in general in the healthcare network.

The narrative was constructed, as mentioned in Chapter 3, from data generated through participant and non-participant observation, semi-structured interviews, group discussions, and secondary documentation review. The first action research cycle evolved from January 2014 until May 2015, the second action research cycle from April 2015 to December 2016. The period of transition from the integrated performance management system implementation at the CHUS to that at the CIUSSS de l'Estrie—CHUS overlaps these two cycles from February to July of 2015.

Figure 7
Timeline of Actions, Decisions and Events Over the Period of the Study



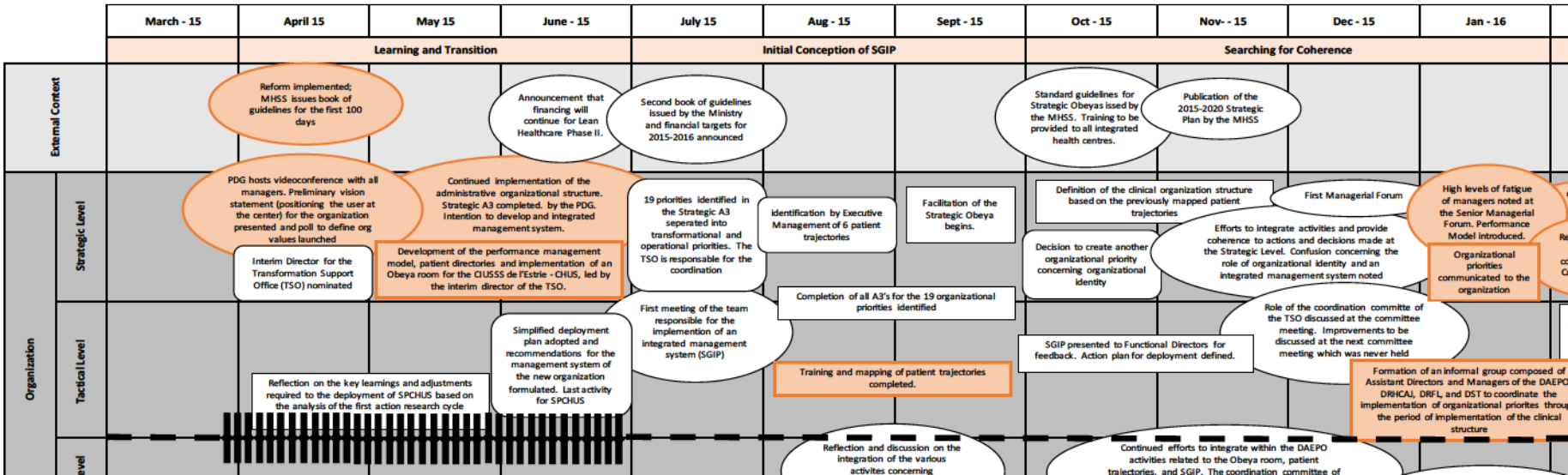


Figure 7
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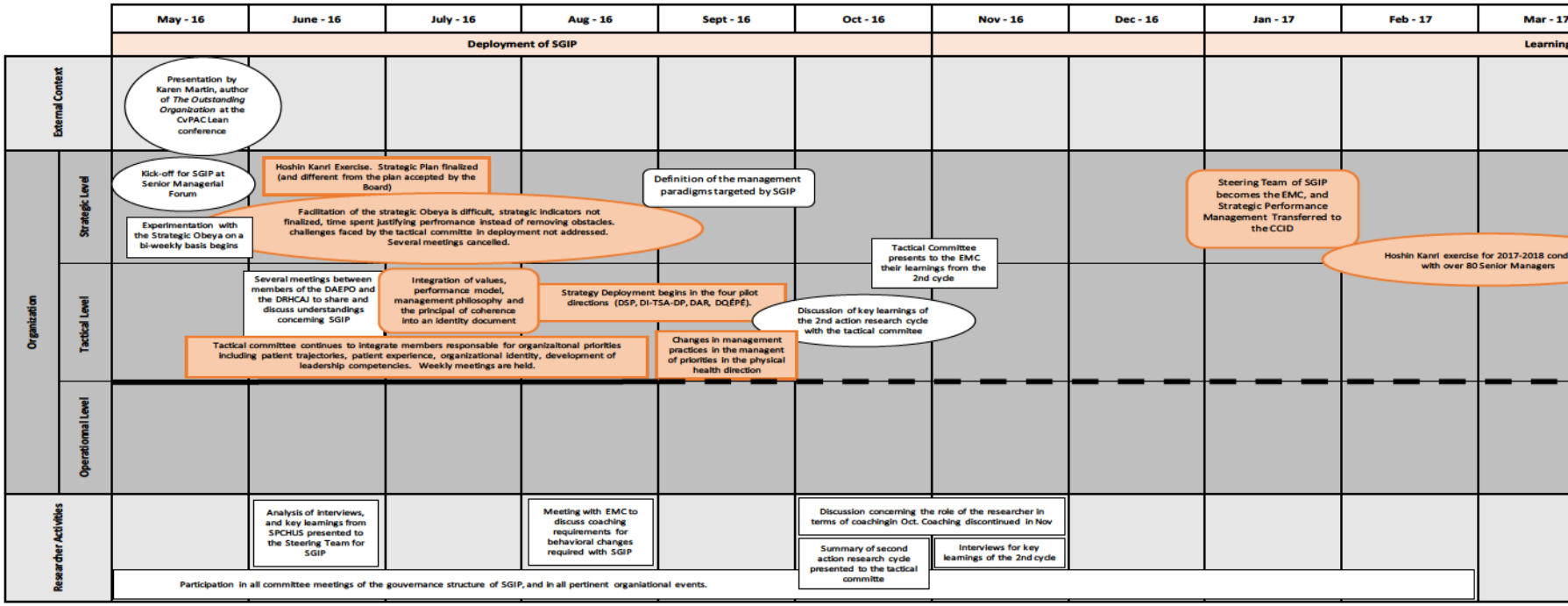
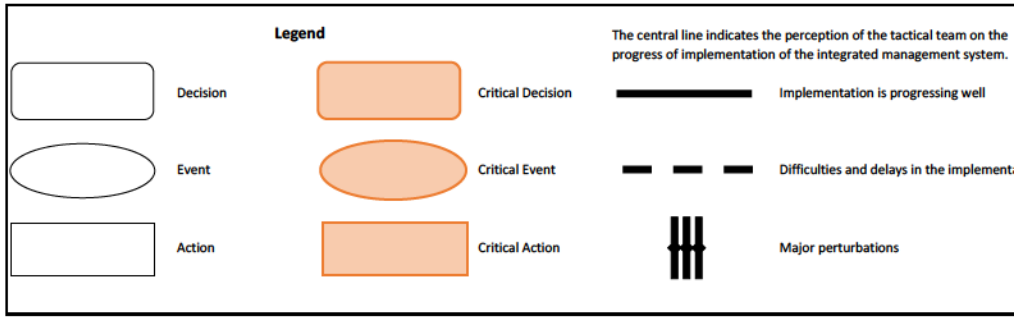




1.1. Narrative of the First Action Learning Cycle with the CHUS

As mentioned in Chapter 1, the CHUS was selected as one of the 16 healthcare establishments to receive funding in Phase II of the MHSS's Lean Healthcare initiative. The program SPCHUS was seen by the organization as a continuation of the profound transformation of the organization that began in 2009, at the request of the Board of Directors, and expressed in the renewed vision of the organization, loosely translated as "The CHUS; more efficient and inspiring, while remaining human." The objective of the transformation was to organize care and services around patient trajectories, to break down the silos of care and move to a matrix form of organization. Lean methodologies would be used in operational management leading to continuous improvement. The intended result of the program SPCHUS would be a cultural transformation, whereby, those working closest to the patient would have much more influence in the decision-making process. The vision and intention of the introduction of SPCHUS were documented in the request for financing as part of Lean Phase II submitted and accepted by the MHSS in October of 2013. The following is the description found in the executive summary of the submission[27].

> À la demande de son Conseil d'administration, dès 2009, le Centre hospitalier universitaire de Sherbrooke s'engageait dans une transformation en profondeur de son organisation. Le projet GPS (Gestionnaire-Performance-Sens) réalisé au cours des deux dernières années aura permis au CHUS d'assurer des bases solides à cette transformation qui aura des répercussions sur tous les niveaux de sa mission, de sa gouvernance et de ses structures, sur ses approches et modes de gestion, de même que sur sa culture et ses paradigmes. Cette transformation est portée par la vision renouvelée d'un « CHUS plus performant et inspirant, à dimension humaine » mise de l'avant dans la planification stratégique 2012-2015 de l'organisation.
>
> L'objet privilégié de cette transformation qui se poursuivra est la trajectoire patiente, perçue comme le lieu où se réalise concrètement l'expérience du patient et de ses proches à l'occasion de son épisode de soins ; la trajectoire patiente est également positionnée comme le lieu d'interprétation, de réalisation et d'évaluation de la performance de l'organisation dans la production des résultats attendus pour les patients ; finalement, la trajectoire patiente

[27] Source : Projet d'implantation de l'approche Lean Healthcare Six Sigma dans des établissements du réseau de la santé et des services sociaux – Appel de candidatures et critères d'admissibilité, Version 0.5, 2013-05-23; document inédit.

> constituera le lieu d'intégration des efforts de l'organisation dans un **mode de gestion « hors silos »** basé sur une approche matricielle.
>
> Cette transformation s'appuiera fondamentalement sur le déploiement extensif et sur l'appropriation intensive par tous les secteurs de l'organisation de **l'amélioration continue (LEAN)** comme mode de gestion des opérations, autant à l'intérieur des trajectoires que dans les services contributeurs à celles-ci. **À terme, le résultat de cette entreprise se traduira par une nouvelle culture organisationnelle** où les ressources terrain occuperont une place prépondérante à l'intérieur de la nouvelle gouvernance qui sera mise en place[iv].

The governance structure of the program SPCHUS is presented in Figure 8, and the role and composition of each of the committees may be found in Table 8. The researcher participated in the meetings of all of the committees with the exception of the Executive Committee.

Figure 8
SPCHUS Governance Structure

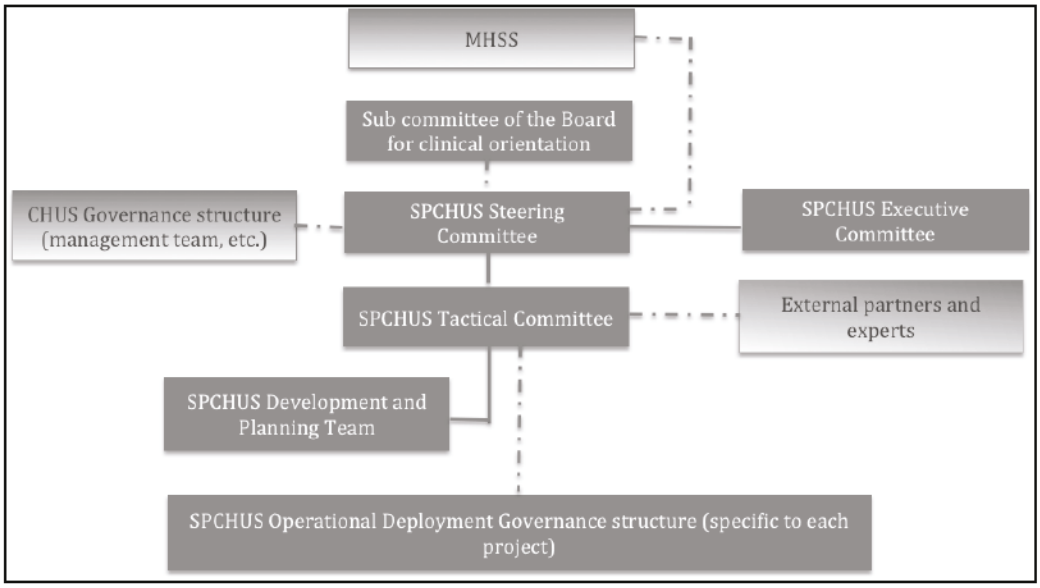


Table 8
Role and Composition of SPCHUS Committees

Committee	Role	Members
Steering Committee Frequency: 90 min every two months	Promote and support the deployment of the performance management system SPCHUS, ensuring its alignment with Vision of the CHUS, specifically concerning the desired organizational and cultural change. Responsibilities include: • Approving the governance structure • Approving the global deployment plan and any subsequent changes • Develop the broad guidelines of the program • Facilitate communication and coordination among the various stakeholders of the organization • Support the Program Manager in actualizing the mandate • Ensure engagement to changes resulting from the program through change management initiatives and a communication plan. • Ensure the availability of the resources required for development and deployment • Monitor the advancement of the sub elements of the program • Support the Action Research project and the integration of the key learnings	The General Manager of the CHUS presides this committee. Members include: HR director; Program Manager; Quality, Planning, Evaluation and Performance Director, President of the Service User committee, Representatives of key stakeholders (Regional Health Agency, Patient, Employee, Manager, Doctor)
Executive Committee Frequency: 90 min every two months	Promote and support the deployment of the performance management system, ensuring cohesion between the system and the other critical initiatives of the CHUS. Validation of key decisions to be brought to the Steering Committee. Ensure that the voice of the customer is being heard.	The General Manager of the CHUS presides this committee. Members include: Program Manager; HR director; Program Manager; Quality, Planning, Evaluation and Performance Director, President of the Service User committee
Tactical Committee Frequency: 90 minutes every two months, prior to the Steering Committee meeting.	Recommend to the Steering Committee the deployment scenario, and provide guidance to the Program Manager throughout the project. Ensure the execution of communication and change management plans, and conformity to the Lean Principles expressed by the MHSS. In executing its responsibilities, facilitate the participation of key stakeholders involved or impacted by the development and deployment of SPCHUS. Responsibilities include: •Analyze recommendations of the Development and Planning Team •Recommend a deployment scenario to the Steering Committee •Ensure measures are implemented to sustain results of the deployment	The Program Manager presides this committee; and the Subject Matter Expert (SME), facilitates Members include: Union representatives (2 per union); representatives of the Development and Planning Team (Continuous Improvement Manager, Clinical

	•Provide opinions and recommendations to the Program Managers concerning the advancement of the program •Analyze progress to objectives and propose adjustments to the Program Manager and the Steering Committee	Manager, HR Manager [DO], Communication advisor).
Development and Planning Team Frequency: began as monthly meetings but changed to weekly (90 minutes or longer) based on the need for a common understanding.	Support the Program Manager in the development and the deployment of the performance management system SPCHUS. It is intended that the team remains active during all stages of the program, but with varying levels of involvement depending on the work to be done. In carrying out its mandate, the committee is expected to integrate the principles and the philosophy of Lean Santé as promoted by the MHSS, and to reflect the vision expressed in the submission for financing. The team is also responsible for the evolution of all elements of the program submitted to the MHSS (included in Appendix XX) and ensure its implementation. Responsibilities include: •Complete the daily continuous improvement model •Participate in the elaboration and validation of the governance structure for the program •Elaborate a deployment strategy •Perform a stakeholder analysis •Identify critical success factors, risks and challenges (FFOM) for the deployment •Recommend measures to ensure the sustainability of the results of deployment	The Program Manager presides this committee; and the Subject Matter Expert (SME), facilitates. Members include: Quality Manager; Continuous Improvement Manager; LEADS advisors (HR Manager and professional in DO); Professional in data management, Professional in performance measures, Patient Experience professional, Clinical Managers.

1.1.1. Transfer of the Program SPCHUS to the Development and Planning Team (January 2014)

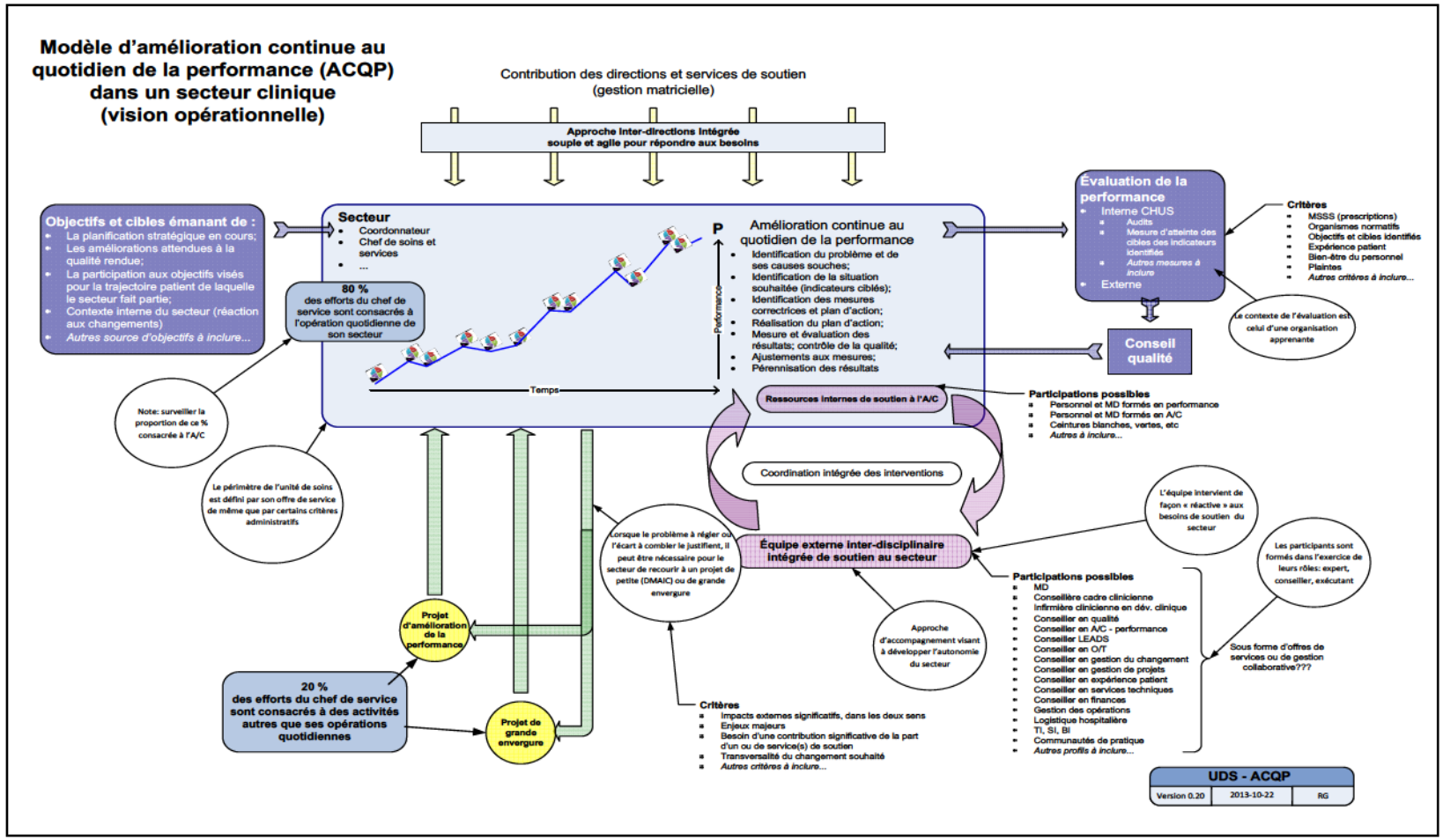
Passing of the Baton

The SPCHUS Development and Planning team met for the first time in January 2014. During this meeting, the detailed program SPCHUS (as presented in Chapter 1 and included in Appendix B) was submitted to the team by the Program Manager, along with the proposed governance structure for the program. As the CHUS was one of the 16 establishments receiving financing as part of Lean Healthcare Phase II, the measures of performance identified by the MHSS to monitor progress of the establishments were also presented to the team. These included:

1. Number of lean projects where a patient/service user is involved;
2. Satisfaction of the patient/service user involved in a lean project;
3. Percentage of lean projects that met their objective;
4. Number of improvement ideas submitted per employee;
5. Percentage of employees involved in implementing improvement ideas;
6. Percentage of doctors involved in implementing improvement ideas;
7. Percentage of employees that have received lean training;
8. Percentage of total training hours dedicated to lean training.

The most pressing objective passed on the team was to plan the deployment of the proposed model for daily continuous improvement (DCI), which was to be introduced in 30% of both the clinical and administrative services by the end of the financing period. A schematic model of DCI was included in the appendix of the document PGM100 presented to the Ministry in the request for financing. The model is reproduced below in Figure 9; it is presented as a visual representation of the complexity of the continuous improvement process that the team was expected to understand and deploy.

Figure 9
Original Model of Daily Continuous Improvement



Following this introduction to SPCHUS, was presented to the team. The deployment suggested was based on three approaches: intensive, extensive and organizational. Intensive deployment referred to deploying all the elements of SPCHUS transversally across patient trajectories. The extensive approach referred to the deployment of the element of DCI progressively across all services in the organization. And organizationally, the functional structure would migrate to a matrix structure, personnel would be trained in transformational leadership, and the balanced scorecard would be introduced for measuring performance across all services within the organization. The extensive deployment of DCI was suggested to begin in those sectors that needed to improve the required organizational practices (PORs) as identified in the audit report of the Accreditation Canada visit in October 2013.

In this first meeting, the group was also presented with the results of some past experiences in implementing daily continuous improvement at the hospital. In preparation for future sessions, it was requested of the team members to reflect on the deployment scenario proposed. It was expected, following another two additional half day meetings scheduled the following month, that the Development and Planning Team would have finalized the deployment strategy to be proposed to the Steering Team. The baton (SPCHUS) had been officially handed off to the Development and Planning Team.

1.1.2. Conception of the Deployment Plan by the Development and Planning Team (February - May 2014)

Appropriation

Several changes occurred in the organization during the period that the Development and Planning Team was working to finalize a deployment scenario. The General Manager (GM) accepted another position in the healthcare sector and an interim GM was appointed (this appointment was formalized in June 2014). Program management for SPCHUS was transferred from the Director of the Direction for Quality, Planning and Performance Evaluation (DQPEP) to the Director of the

Direction for Professional Services (DSP). It was felt that transferring the responsibility to the clinical sector would facilitate the participation and adherence of the medical staff to the project. A subject matter expert (SME) was also named, providing necessary support to the Program Manager in facilitating the various committee meetings and providing guidance on the development of the various elements of SPCHUS.

Two half-day meetings were held during the month of February, with the expectation that the deployment would be finalized at the end of the second meeting. The progress of these meetings testified to the participants' confusion concerning their understanding of the DCI model, the final goal behind its deployment, and the link between the model and the achievement of organizational strategic objectives. Despite this confusion, ten key components essential for successful deployment were identified and a mapping of the services familiar with the concepts of DCI and/or lean were completed during the first meeting. Based on this information several modifications to the original deployment scenario were proposed.

At the beginning of the second meeting, team members reflected on their progress. The discussion reflected a disparity in the participants understanding in a variety of areas: what exactly would be deployed; whether key success factors in services identified for potential deployment were present; the extent of change required in managerial practices; and the specific problem to be addressed through the deployment of SPCHUS in general, and DCI in particular. Despite these discrepancies in understanding, a scenario was proposed by the original program manager and adopted by the team members whereby conformity to required organizational practices (PORs) by November 2014 would be managed through a top-down rectification project to improve safety and security of patients, while deployment of DCI would be deployed based on voluntary participation with the objective of reaching 30% of the clinical and

administrative services by 2017[28]. This scenario was based on a guide for preparing organizational change suggested by a consulting group.

The rectification in terms of patient safety and security practices was to be addressed as a large scale urgent change. The approach to this change strategy would be top-down, mandatory and extremely structured. The implementation of DCI to integrate improvements that would positively impact patient safety and security was considered as a large scale non-urgent change, and the suggested strategy was a combination of cascading and contamination. The change was to be cascaded throughout the various sectors by the hierarchal superior, who would act as a coach, beginning with those areas that volunteered to participate. This type of approach is considered voluntary and participative, while at the same time formal and structured.

Six phases were identified in the deployment plan. These included: 1) training for the development and planning team; 2) awareness training for all employees; 3) training concerning the use of the time dedicated to proximity management for managers and supervisors (DCI and a safety culture); 4) facilitating and supporting the implementation of DCI in the identified sectors; 5) assuring coherence in communications and all major projects with the DCI model; and 6) developing a communication plan as quickly as possible. The specific actions for each of these stages of deployment were identified along with the groups responsible, and this was communicated to the steering team in mid-February. The executive committee accepted the recommendations, suggesting only minor modifications to the essential components for deployment.

During the month of March, the newly appointed Program Manager and the SME became more fully acquainted with the program, completed the appointment of members to all the committees in the governance structure, finalized the frequency for

[28] From the researcher's field journal (journal 1 page 12), a note was made questioning whether a model can be deployed without an understanding of what it represents in terms of change.

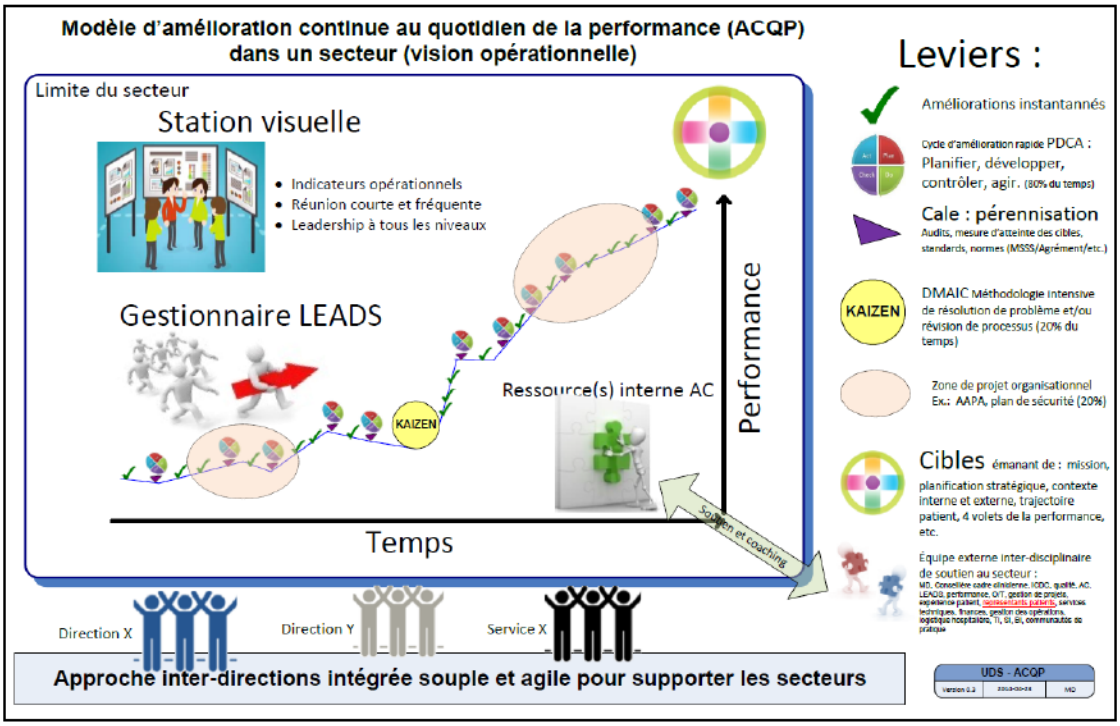
the committee meetings and began reflecting on the training required for the deployment of DCI.

Sense-making

The Development and Planning team met again in April 2014, and would continue to meet monthly. Now charged with deploying SPCHUS based on the plan approved by the executive committee, the attention of the team turned to understanding and more importantly, to integrating each of the five dimensions comprising the program SPCHUS. During this period, senior management at the CHUS attacked one of the five elements of SPCHUS; focusing on major projects that provide value to the patient. The management team reviewed the approximately 150 projects within the organization and prioritized 5 that were critical for the organization and the patient and would be monitored closely: the completion of the patient safety and security plan; the execution of the talent recruitment and retention plan; acquisition and integration of volumetric pumps from a new supplier; implementation of the approach adapted to an aging population (mandated by the Ministry); and SPCHUS.

A revised and simplified conception of the DCI model (see Figure 10), representing the sense made of DCI of the team, was developed by the SME and presented at the team meeting in April (it would continue to be developed in subsequent meetings over the next several months). Also introduced was a lean maturity measurement model, developed by members of research centres (Pole Santé, and IRISSS) at the HEC and UQTR, which potentially could be exploited by the group to measure progress of the lean deployment at the CHUS.

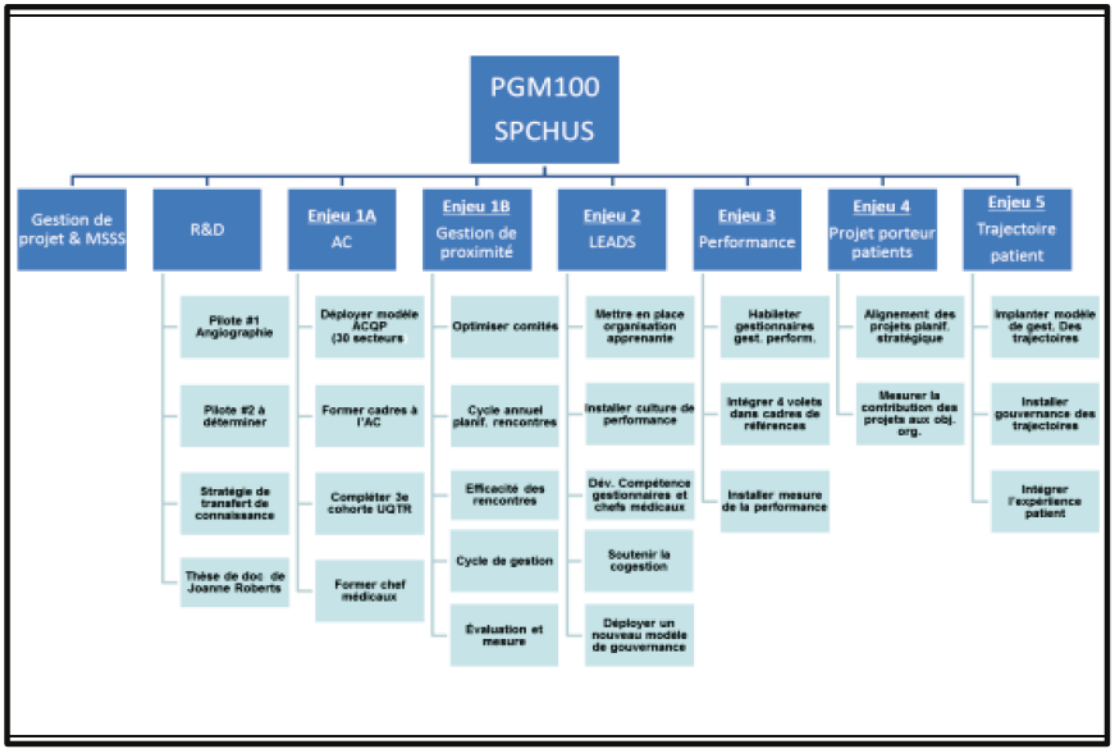
Figure 10
Simplified Model of DCI



Source: Internal document created by the Development and Planning Team

Following the February team meeting, the owners of each of the orientations of the SPCHUS began working on their specific objectives (Figure 11 provides a schematic of the dimensions and orientations). As can be seen in Figure 11, the program structure was organized by project "lots" whereby each of the objectives was independent of the others. The owners were all members of the Development and Planning team and had organized separate meetings to develop the dimension under their responsibility. It became apparent during these meetings that the interdependency between the five dimensions of SPCHUS had not been fully considered.

Figure 11
Schematic of the Dimensions of SPCHUS

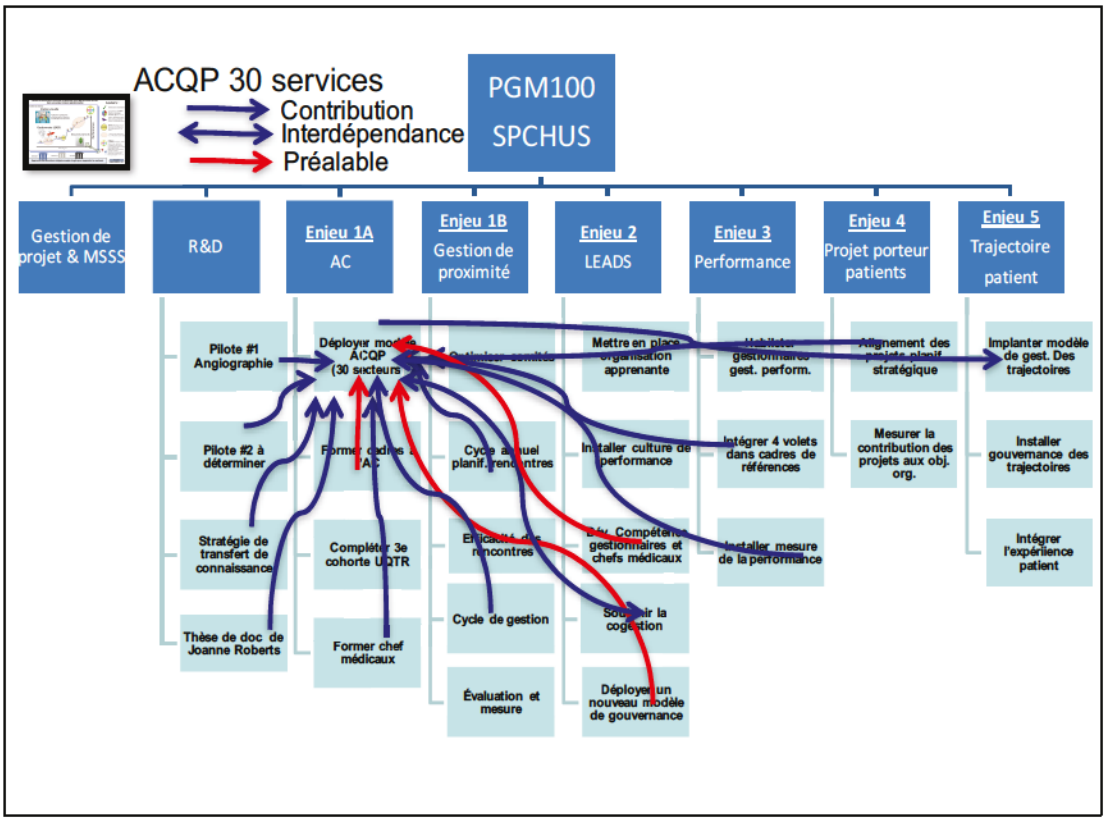


Source: Internal document created by the Development and Planning Team

The inter relationship between the dimensions became evident, and team members noted that they could not be worked on independently without considering their impact on the other dimensions of SPCHUS. In addition, a majority of the objectives were key to consider in the implementation of daily continuous improvement (for example, considering patient experience, an objective under the patient trajectory dimension was critical to determining which areas would be important to improve in each of the sectors, as would deploying key indicators, an objective under the dimension of the balanced scorecard in order to ensure that improvements were aligned with key organizational priorities). Figure 12 visually represents the interdependency of the dimensions of SPCHUS, as they relate to the team's conception of the model of daily continuous improvement. This representation

was developed over the April and May meetings of the Development and Planning team.

Figure 12
Interdependency of the Dimensions of SPCHUS



Source: Internal document created by the Development and Planning Team

1.1.3. Planning for Deployment of SPCHUS and Revision of the Deployment Scenario (June - November 2014)

Communication of SPCHUS to the management team

The most notable event in June was the official 'kickoff' for SPCHUS during the management forum, whereby senior management announced their intention to transform the organizational culture through the deployment of SPCHUS. The vision for the change was explained by the General Manager and it was clearly mentioned that one of the key changes with the management system would be to focus on the organization's daily operations (80% of the work to be done daily). The remaining 20% of daily work would be concentrated on the implementation of the five key value

improvement projects that the organization had previously announced. This represented a major change in focus. Historically, project work was valued to a much greater extent than the daily management of operations.

The 'kickoff' included a presentation of the background to the development of SPCHUS and its financing within Lean Healthcare Phase II, and then the Program Manager and the SME presented of the five dimensions SPCHUS.

Following the presentation, the managers attending the meeting were asked to reflect and discuss on two questions. The first question concerned what they needed as managers to integrate SPCHUS in their daily activities; and the second concerned what was needed at an organizational level to succeed with desired transformation. The elements were documented and discussed by the development and planning team during the monthly meeting and integrated in the key success factors for the deployment (while many of the elements were addressed in the 12 original factors, another 13 elements were added). The added elements are important to note as these themes will be expressed by participants at various different times throughout the research project. They revolved around the desire of managers to: move from the theoretical concepts to action as quickly as possible; have a clear definition of the expected behavioural changes in management practices; witness senior management role model the expected behaviours; and the opportunity to participate in the development of the methodology of SPCHUS.

The general manager concluded the 'kickoff' in the closing comments by indicating the importance of moving ahead with the implementation of SPCHUS. The organization would be placing much more emphasis on daily operations; on doing things "differently in a public healthcare organization." The language used left the impression that changes in practice were required on the part of the managers seated in the audience, but not necessarily by senior managers. This was noted, and clarified by one of the other senior managers, who indicated that changes were not only required by 'you' but by 'us,' and that 'we' are committed to making this change.

Following the management forum, the Steering and Tactical Committees for SPCHUS met for the first time. A joint meeting was held to introduce the committee members to the program. An apparent theme from the 'kickoff' and from the introductory committee meetings was the view of SPCHUS as something 'much larger than Lean.'

Conceptual Integration, Further Sense-making and Revision of the Deployment Scenario

The period from July to November was characterized by intense work by the Development and Planning team to continue to integrate and appropriate the various dimensions of SPCHUS into a revised deployment plan for DCI. The monthly frequency of the scheduled meetings was inadequate to complete this work; therefore, forty hours of collaborative meetings were held during the month of July. Notable during this period of development was the announcement of the possibility that the financing for Lean Phase II would be suspended, given that there were few tangible short-term results in terms of improvement in healthcare performance. Understandably, the team felt pressure to begin deployment as quickly as possible.

Three important steps were taken by the team during the summer months towards integration and appropriation. First, based on the feedback from the management forum in June, team members decided to look at what SPCHUS meant in terms of a change to management practices for the organization. As transformational leadership was one of the 5 dimensions of SPCHUS, the LEADS framework was presented to the team. This framework was chosen over others due to its pertinence and widespread use in the Healthcare sector, the presence of a community of practice, and its applicability to all employees (not limited only to those in formal leadership positions). The framework includes five areas of competence (lead self [L], engage others [E], achieve results [A], develop coalitions [D] and transform systems [S]). Four capabilities are identified for each of the competencies, and specific examples of

behaviours are provided. From this framework, and an evaluation of the current situation within the CHUS, a list of management 'paradigms'[29] (actual and desired) was developed. The management paradigms, presented in Table 9, would become important to the Development and Planning Team, and to participants in the deployment of SPCHUS, as the desired paradigms would be used to evaluate the progress of the anticipated change in management practices.

Table 9
Management Paradigms

Current	Desired
Patient viewed as a passive actor	Patient viewed as a partner
Micromanagement	Shared leadership
Manager as expert	Manager as coach and role model
Administrative functions provide orientations	Administrative functions support clinical operations
Periodic measurement of results	Daily indicators of performance
Decide and direct	Consult and decide
Conception of the perfect model	Experimentation and continuous improvement
Reactive	Proactive
Short-term results	Long-term vision
Blame for errors (search for the guilty party)	Learning opportunity (search for the cause within the process)
To Do list	Prioritization of critical actions
Take on all responsibility (control)	Delegate and develop accountability
Value project work	Value daily operations

In addition to the management paradigms, the team also identified indicators that would be used to measure progress of the introduction of SPCHUS based on their

[29] This is the term used by the team members to describe the typical example of the management archetype within the organization, as it currently is, and the vision for the future.

understanding of what was trying to be achieved[30]. Figure 13 summarizes these indicators.

Figure 13
Performance Measurements for SPCHUS

Performance Indicators SPCHUS		
Indicators of Results of the Deployment of SPCHUS		**Goal**
Numbers of sectors that improve their performance (clearly demonstrated through performance indicators).		10
Number of patient pathways that have improved their performance		2
Process Indicators		**Goal**
DCI	No. of sectors where a minimum of 3 PDCA's (A3's) have been completed.	10
	No. of sectors where a minimum of 10 "just do it" improvements have been introduced	10
	No. of sectors where a patient has been integrated in daily continuous improvement of performance.	10
Continuous Improvement	No. of sectors that use the toolkit for DCI.	30
LEADS	No. of sectors where the managers/supervisors have been coached in LEADS.	10
Management System	Definition and prioritization of critical organizational objectives	
	No. of patient pathways mapped.	2
	No. of patient pathways managed.	2
	Ratio of projects prioritized in the project portfolio.	100%

As a second step towards integration and appropriation, the team discussed their understanding of the objective of deploying the daily continuous improvement model. The key aspect of daily continuous improvement, as documented in many publications on lean, is the use of key measures, aligned with the overall strategic objectives of the organizations, allowing for the identification of issues impeding favourable results, and thus aligning improvement in daily activities. The measures of specific services and departments are based on the critical key indicators that the organization has selected that measures the organizational performance. These 'critical few' are commonly referenced in the literature as True North indicators, orienting the entire organization

[30] While the Ministry had specified the indicators of progress that would be used for all of the establishments financed in Lean Phase II, the Development and Planning felt that they did not adequately capture the intention of the transformation intended with the SPCHUS.

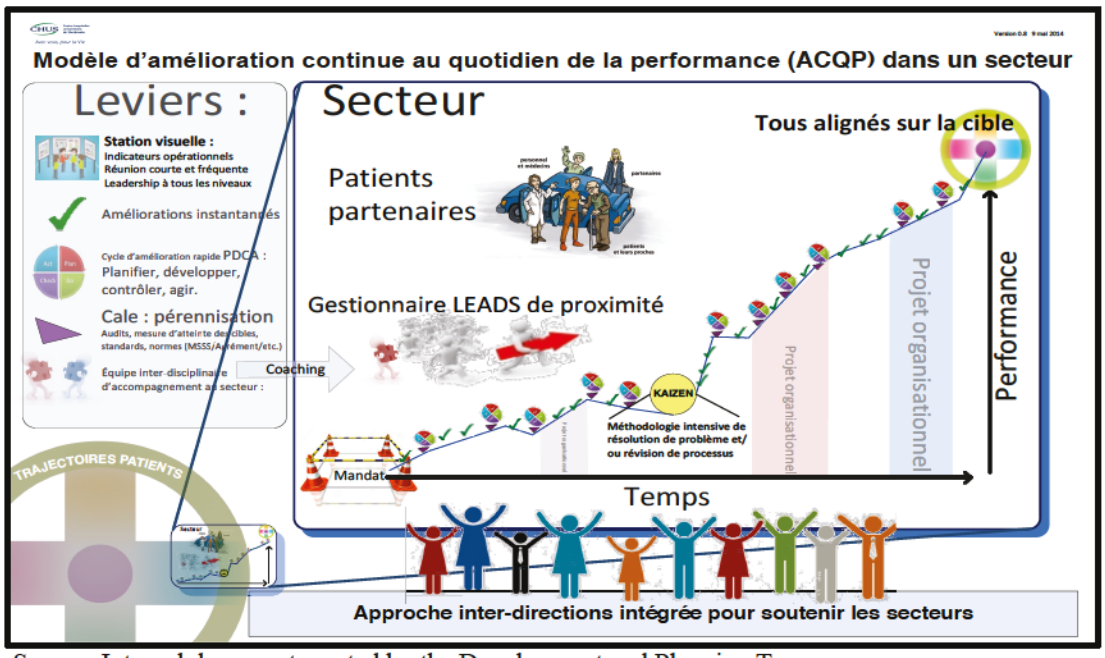
towards the vision. At the CHUS, 30 indicators were monitored monthly. Several indicators had been identified to measure progress on objectives in the strategic plan, and another set of indicators were used to monitor operational performance in the four quadrants of their balance scorecard. The team felt that the lack of refinement to a critical few would prevent an alignment of all sectors to common organizational objectives and, hence, make improvement in organizational performance difficult.

Given the orientation documented in the deployment scenario in February (the deployment of continuous daily improvement to improve the safety and security of patients), and the perceived necessity for defining the critical performance indicators, the team discussed the possibility that the TMPE (taux de mortalité potentiellement évitable)[31] could be the 'True North' indicator. This, however, was not retained by the team, as the members believed that the Board of Directors was not ready for this level of transparency, nor was the organization itself comfortable in identifying a single 'True North' indicator, given the perception of the organizational leaders that performance was achieved through balanced results in each of the four areas included on their balanced scorecard (process, patient, resources, practices).

The third step in integrating and appropriating the elements of SPCHUS, daily continuous improvement was the positioning of DCI within patient trajectories. Also included was the expected contribution of the patient as a partner in improving processes. The updated schematic model of daily continuous improvement, as seen in Figure 14, reflects the work on integration over this period.

[31] Loose translation: potentially preventable mortality rate

Figure 14
Schematic Model of Daily Continuous Improvement

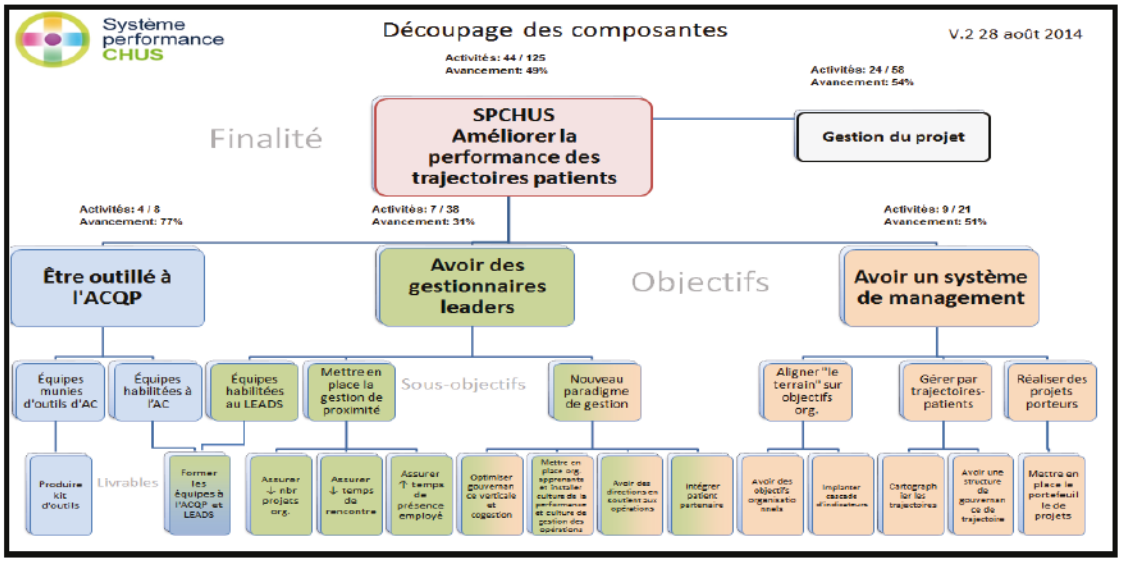


Source: Internal document created by the Development and Planning Team

The figure illustrates the positioning of DCI within a patient trajectory or pathway (lower left corner of the schematic). This is the starting point: performance improvement within a sector cannot be done without understanding the service's position within a patient trajectory. Improvements in a service need to consider the overall flow of the patient and cannot resolve issues by moving the problem either upstream or downstream in the trajectory. Daily continuous improvement requires facilitation by supervisors and managers that demonstrate leadership skills found in the LEADS model, and in concert with patients, who are seen as partners in their treatment (in the centre square of the schematic). The identification of improvement activities must also be aligned with the overall strategic objectives of the organization (the target in the top right corner of the schematic), and members of various administrative functions will support the service in their improvement projects (the people supporting the middle square at the bottom of the schematic). Contrasting this with the original schematic of DCI (Figure 9), one can see the evolution in understanding of the team.

As further testament to the integration of the dimensions of SPCHUS by the team during the summer, the schematic of the dimensions and orientations of SPCHUS was updated as may be seen in Figure 15.

Figure 15
Revised Schematic of the Dimensions of SPCHUS



Source: Internal document created by the Development and Planning Team

These images represent the progress made in sense making and reflect the attempt to break away from the traditional project management thinking of defined 'lots' of projects that make up a program, and move to a more holistic and systemic view of the program SPCHUS. Contrasting Figure 15 with Figure 11, the reader will note that the particular 'lots' such as proximity management, or LEADS, no longer stand alone as an individual project, but instead are projects that are required for implementing DCI, for developing leadership according to the desired paradigms, or for implementing a management system.

The work on integrating the dimensions of SPCHUS, led the group to review the deployment scenario that had been approved in February 2014. The cascade

approach to deployment was maintained, however, it was specified that each 'cascade' would involve the program co-managers, two department heads, and the services within their responsibility. Subject matter experts (in lean, LEADS and patient experience) would be assigned to each of implementations. While the proposal of a single True North indicator was not retained by the team, it was proposed that the plethora of indicators currently used to monitor performance by senior managers be refined to five key indicators that could be deployed to all services. The involvement of the General Manager and the co-managers of the DISC was identified as critical to the success of the deployment.

To validate the feasibility of this proposition, the SPCHUS Program Manager and SME met with three clinical managers. During the meeting, concern was expressed on how they would be able to find time for daily continuous improvement, given their already demanding schedules, indicating that improvement efforts would need to be done on overtime[32].

The updated deployment strategy was presented to the Tactical and Steering Committees in September 2014. Tactical committee members suggested that certain sectors should be avoided in terms of deployment considering current work relations. They also questioned why the work on the POR's and the deployment of DCI were to be handled separately, believing that it would be an interesting opportunity to show practically the use of DCI in meeting organizational objectives. Despite this question, both committees approved the updated deployment strategy proposed by the development and planning team, and continued with a separate approach for handling the POR's.

As the team moved into the preparation for deployment, planned to begin in December 2014, the proposed Bill 10 (an act to modify the organization and

[32] The shift from "we're too busy to improve" to one of continuous improvement is noted in the scientific literature. Most organizations find their staff are too busy as the processes are so 'broken' that much time is wasted in finding ways to work around them (Toussaint *et al.*, 2017).

governance of the health and social services network by abolishing regional agencies, as previously mentioned) was announced on September 25, 2014. The announcement created insecurity and confusion. A considerable amount of time was spent in the organization trying to understand how the bill would impact the CHUS and the healthcare network across the Eastern Townships. Open forums for the employees of the CHUS were frequent during this period, and it was often emphasized the importance, despite the turbulence, of concentrating on maintaining care and services. As evidence of the commitment of the organization to concentrate on operations, changes were made in the organizational structure. The senior management team would continue to meet and focus on strategic issues, but a management committee would be introduced that would meet weekly with the goal of managing operations at a strategic level. In addition, the general manager made it clear that the deployment of SPCHUS would continue, and if possible, the timeline accelerated, as it was felt that this was an important component of the desired operational focus.

The announcement of Bill 10 would influence considerably the advancement of the implementation of the management system based on lean principles as will be seen in the narrative for the remainder of the research project.

Preparation for Deployment

Against this background of uncertainty, the Development and Planning Team began preparations for the deployment. The governance structure of SPCHUS was modified with the creation of a Facilitation Team, which would be responsible for coordinating and facilitating the deployment. The team was composed of the coaches (subject matter experts in lean, LEADS, and patient experience), the supervisor of the lean professionals, and was facilitated by the SME of SPCHUS.

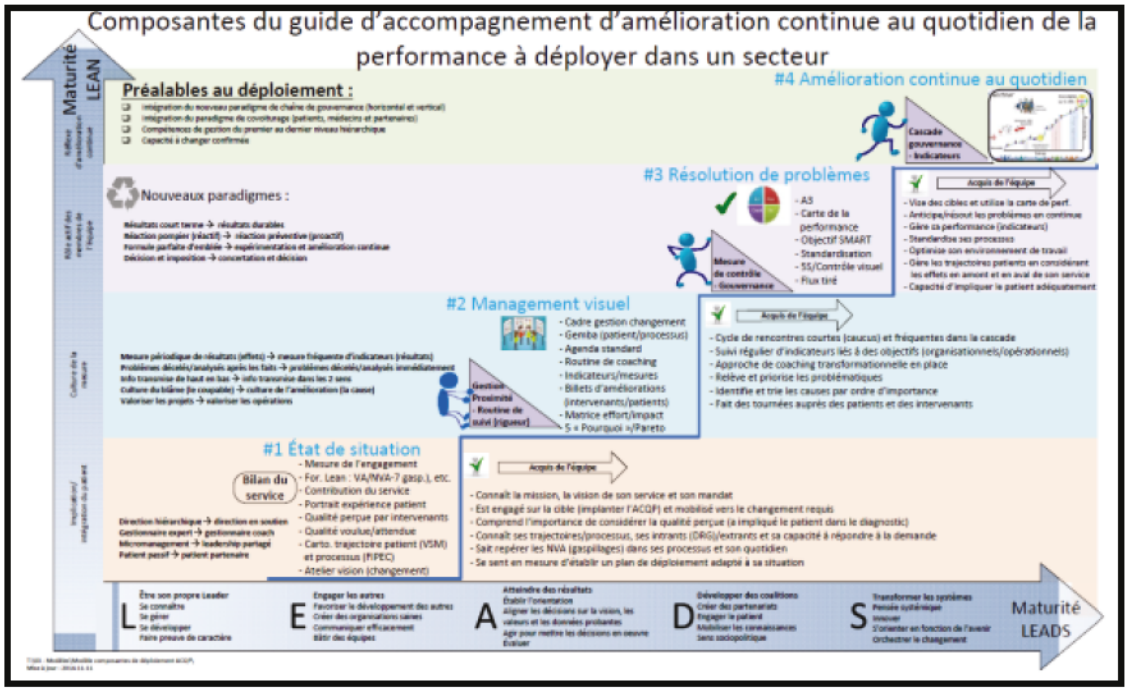
While the Development and Planning Team had conceptually integrated the concepts of SPCHUS, and made sense of the interdependency of the various dimensions, the Facilitation Team struggled with what this would look in action like

during deployment. This was particularly evident in discussions concerning the coaching that the team would be providing during deployment in the three areas of lean, LEADS and patient experience. Questions arose as to who was ultimately responsible for providing the coaching. Representatives of human resources felt that coaching was under the responsibility of the Department of Human Resources and Education (DRHE), given that the only two people in the organization trained as LEADs coaches belonged to this department. Those team members that had participated in Kaizen activities over the years felt that they had solid experience in coaching management practices required in a lean environment, in addition to their expertise in lean tools and methodology. Expertise in patient experience was concentrated in one or two individuals in the organization, and at this point in time had not been transferred to others in the organization. The concept of a coaching 'cell' was adopted as the approach for facilitating deployments. The cell was composed of people with expertise in transformational leadership, lean, and patient experience who would work with the client program managers, department heads and service coordinators throughout the deployment. The members of the cell would develop the material together and share their expertise during the deployments.

A detailed deployment guide for the coaches and the materials required for training were finalized in the fall, and three client programs targeted for deployment were also chosen during this period: Medical Imagery, Medical Biology and Pharmacy. Critical care was identified as the fourth client program, but would be deployed only when one of the other three had been completed.

A schematic of the deployment model is presented in Figure 16, and shows the various stages required for a sector to achieve maturity in lean and in LEADs.

Figure 16
Deployment model of the components of DCI



Source: Internal document created by the Development and Planning Team

Again, the figure is provided for illustrative purposes, and shows the amount of detail and planning that had gone into design of the deployment guide. Each stage of deployment was designed to target the desired changes in management practices. Prior to implementing visual management, the objective of the first stage was to facilitate an understanding of the service and to create a vision of improvement. This stage included eight different steps, including an introduction to SPCHUS, measuring actual performance, initial training on DCI, positioning the contribution of the service in the patient trajectory, identifying critical performance indicators, performing value stream mapping, and finally creating a detailed deployment plan specific to the service.

At the completion of stage 1, six steps were suggested to facilitate the implementation of visual management. At the end of the six steps, the service would be using daily caucuses with visual management to monitor and improve performance. Further training and support would be offered to continue to improve problem solving

methods, and coaching would continue until the service had reached the final stages of maturity.

Parallel to the choice of sectors for deployment of DCI and the development of the deployment guide by the Development and Planning Team and the Facilitation Team, it was decided by Senior Management to introduce management by patient trajectory in two areas; Oncology and Mental Health.

1.1.4. Deployment in a Turbulent Environment (December 2014 - April 2015)

Deployment Kick-Off

In December, deployment began in the first of the client programs. The facilitation committee had proposed that the deployment begin with a kick-off meeting, presided by the general manager and the co-managers of the Interdisciplinary Department of Clinical Services (DISC), to the client program managers, department heads, coordinators and medical staff for all three pilots. It was felt that by formalizing the kick-off of deployment, and having the senior managers deliver the key messages concerning their vision of and reasons for the change, it would be taken seriously (and not thought of as a passing fad) and would reinforce the importance of the change. Unfortunately, with the turbulence in the system caused by the pending adoption of Bill 10 it was not possible for the senior managers to find the time for a kick-off of this breadth. The team proposed alternatives for a kick-off in each individual client program. Nevertheless, the commitment and the understanding of the critical role of senior management to SPCHUS were beginning to be questioned by members of the Development and Planning Team.

Prior to the first kick-off meeting, the choice of sectors for the deployment was announced to the Tactical and Steering Committees. Union representatives, members of the tactical committee, were unhappy with the choice of the client programs indicating that one of the sectors chosen had serious labour relations issues (note that

at an earlier meeting they had mentioned the areas where labour relations were problematic). In addition, national union representatives were reflecting on whether they would recommend that local unions stop their involvement in the governance committees in the 19 financed establishments. At the CHUS, the representatives felt that there was little room in the tactical meeting to provide input on the deployment, and wondered aloud whether their participation was more for show than anything else.

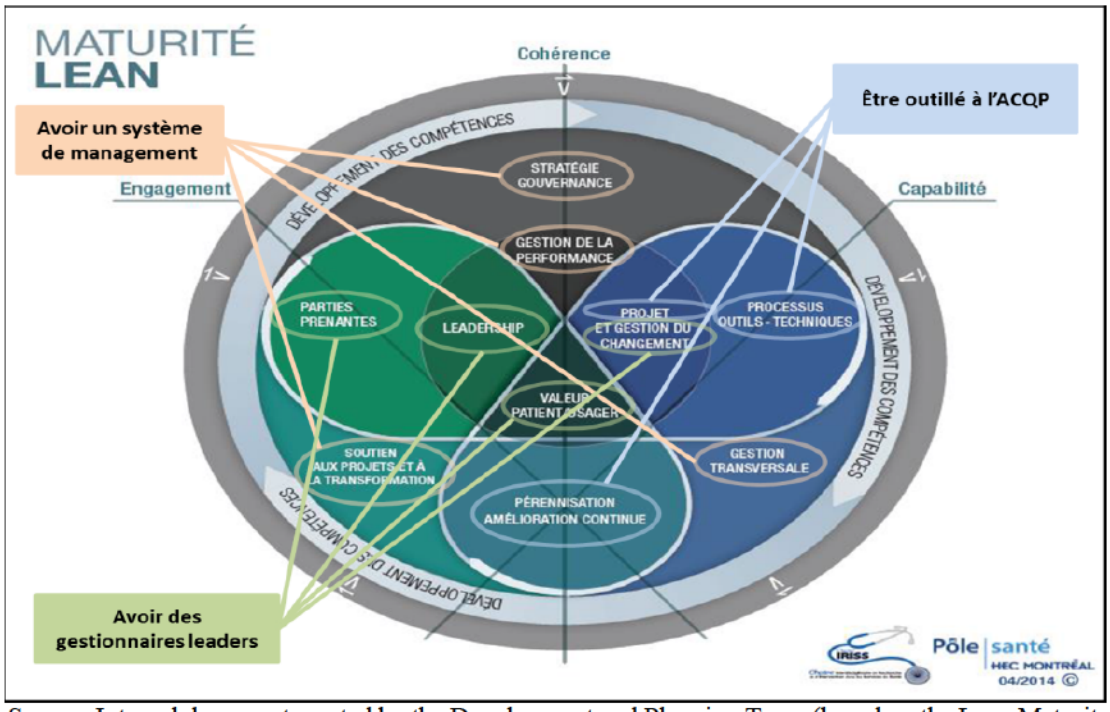
The pharmacy department was the first pilot to begin deployment. The General Manager and the Director of the DSP presented to the group the program SPCHUS and the reason for its deployment within the organization. The three elements of the program integrated in daily continuous improvement (lean principles, the leadership behaviours required and the integration of the patient experience in daily performance improvements) were then described. Following this deployment, and with the deployments for the other pilots planned for February, the Facilitation Team identified more specific indicators that would measure the success of the deployment of DCI. The measures introduced were used in the weekly meetings of the team to monitor progress and make improvements in the deployment and included:

A. Evaluation of the management paradigms adopted (number adopted/number targeted for improvement);
B. Number of problems identified and resolved;
C. Number of completed A3's;
D. Number of daily huddles completed, and percentage of team members involved.

In January 2015, all organizations receiving funding as part of Lean Phase II were requested to evaluate their lean maturity. The tool proposed measures the maturity, appropriation, and deployment of a lean approach across three transformational axes determined through empirical research. Figure 17 illustrates the model, with ten elements that gravitate around the central element; creating value for the patient/user. A total of seventy-seven components are included within the ten elements, measuring objectives achieved, success factors, critical conditions necessary for implementation, and challenges of the deployment of a lean approach (Jobin and Lagacé, 2014). For the Development and Planning team the elements of the maturity

model reflected the dimensions of SPCHUS, thus the team proposed that it could be used to measure the progress of deployment, and ultimately the success of the desired transformation. The dimensions of SPCHUS have been overlaid on the maturity model in Figure 17, demonstrating the similarity of the models.

Figure 17
Lean Maturity Model



Source: Internal document created by the Development and Planning Team (based on the Lean Maturity Model developed by the IRISS and Pôle Santé.

The Senior Management Committee completed the evaluation as a group in January 2015, at only their third meeting with the new configuration of the organizational structure introduced in December 2014 (creation of the senior management committee with a strategic view of operational activities). This was the first time that the members of the management team participated in discussions concerning lean and SPCHUS, and what it meant for the organization. With seventy-seven individual items to evaluate, discussion was unfortunately limited. Answers were provided to questions of clarification, however, there was no discussion concerning the

ratings given. Participants responded to each question with a clicker and the data was automatically compiled.

As the deployment advanced, members of the Facilitation Team and the Development and Planning Team became increasingly aware of a difference in understanding of SPCHUS with senior management. At the request of the Development and Planning Team a meeting was held at the end of January 2015 to discuss in more detail the origins of SPCHUS, and to clarify the differences between a lean methodology and a lean management system. The general manager, the director of the DQPEP, the co-directors for the DISC, and representatives of the Development and Planning team were present at the meeting. The integrated view of SPCHUS developed by the team was presented, and the necessity for modelling the desired behaviours at the most senior levels, and providing True North indicators to align improvements with overall strategic objectives was emphasized. The discussion also highlighted the importance of daily interactions in maintaining or changing culture.

The directors indicated their support for the integrated view of SPCHUS. Several challenges, however, were mentioned. Firstly, the political nature of the external environment, and the top down management practices of the Ministry were perceived as an important challenge in the implementation of an integrated performance system based on lean principles. Secondly, moving from current managerial practices to desired practices were mentioned as being difficult given that it led to the distinct feeling of losing control (identified as being extremely uncomfortable by the directors in attendance at the meeting). Nevertheless, senior directors did agree to determining key strategic operational indicators to be cascaded across the organization, and to the use of the maturity model as a method for measuring the evolution of the management system.

Creation of the CIUSSS De l'Estrie CHUS

On February 6th, Bill 10 was adopted into law under an exceptional legislative procedure (gag). The intention of the reform, as indicated by the MHSS, was to « favoriser et de simplifier l'accès aux services pour la population, de contribuer à l'amélioration de la qualité et de la sécurité des soins et d'accroître l'efficience et l'efficacité de ce réseau. »[33] In other words, to re-centre attention on the core business of the healthcare network: clinical operations. The attention of the CHUS turned towards preparing for the reform to take effect on April 1, 2015, and to responding to questions and concerns of the organizational members. When the new law was to be implemented, 1300 management positions across the provincial health network would be abolished. The period of preparation for the implementation of the reform was marked by efforts to position the program SPCHUS as the management system within the new organization and to position lean within the healthcare reform.

As part of these efforts, members of the ministerial department responsible for overseeing Lean Healthcare Phase II (la direction de la planification de la main-d'œuvre salariée et médicale et du soutien au changement)[34] visited the CHUS. The visitors perceived that through the program SPCHUS, lean had evolved from a project and was moving towards an integrative performance management system. After attending a daily caucus meeting, they were encouraged to see the enthusiasm of the participants and the evidence of improvements made, expressing their certainty that this would continue despite the major structural changes expected with the implementation of the reform. During a meeting with the Senior Directors of the CHUS at the end of the day, the General Manager reiterated his belief in a lean management system. However, the difficulty of this was recognized as within the new Integrated Health Center for the Eastern Townships (CIUSSS de l'Estrie – CHUS), the individual

[33] Loose Translation: Promote and simplify access to services for the population, contribute to improving the quality and safety of care and increase the efficiency and effectiveness of this network. Source: http://www.msss.gouv.qc.ca/documentation/salle-de-presse/medias/Presentation-info-techniquePL10.pdf , and accessed on December 11th, 2014.

[34] Loose translation: Directorate of Workforce and Medical Workforce Planning and Support for Change

establishments demonstrated varying levels of lean maturity. In fact, many had adopted other management models such as Planetree or Hôpital promoteur de santé (HPS). The senior directors from the CHUS indicated their desire that these models be integrated into the management system of the new organization.

The last organizational open forum for the CHUS (as an independent entity) occurred in mid-March. The forum served to present the accomplishments of the organization and provide information on the reform implementation. The achievements were presented under the four quadrants of the balanced scorecard. The general manager indicated his pride in the shift to focusing on the patient over the last year, particularly throughout a period of turbulence and uncertainty. The four quadrants of the performance scorecard were stated to have improved in a balanced fashion, and the quality and safety of service to patients were unaffected by the pending implementation of Bill 10. SPCHUS was noted as a key to this improvement, and organizational members were encouraged to transfer learnings and practices to the new organization. Specific improvements were identified verbally, however, visual measures of improvement were not presented.

As the organizational structure for the CIUSSS de l'Estrie—CHUS would not be announced until the end of March, it was indicated that the existing governance structures of the individual establishments would remain in place. Over the months of March and April, the President and CEO (PDG) and the Assistant PDG (PDGA) were nominated, and staffing was completed for several of the director level positions (such as for the departments of Human Resources, Communication and Legal Affairs [DRHCAJ], Financial Resources and Logistics [DRFL] and the Assistant General Direction of Programs [DGA]).

On March 31, 2015, 289 management positions within the CIUSSS de l'Estrie—CHUS were abolished. Of this total, 31 positions were already vacant, 57 individuals decided to leave the organization and 201 chose the option of being

relocated within the healthcare network. Employees of the regional health agency were administratively transferred to the CHUS and the CSSS-IUGS while awaiting the implementation of the final organizational structure for the CIUSSS de l'Estrie — CHUS.

On April 1, 2016, the PDG of the CIUSSS de l'Estrie-CHUS hosted a videoconference with all managers in the newly created organization. A position statement ("un citoyen, une organisation réinventée pour toute la vie"[35]), developed with the ex DG's prior to April 1st, was proposed to the management team of the new organization. With their feedback, this statement became "En Estrie, ensemble, innovons pour la vie"[36], and represented the vision of the CIUSSS de l'Estrie — CHUS. The new organization (the second largest in Quebec) covers 12,820 km^2, offers services from the first line (family practitioners) to specialized and super specialized care to the very young and to the aging, provides care and services to 450,000 people over 101 points of service, employs more than 17,000 employees and more than 1000 doctors, and has an annual budget of 1.1G$.[37] It was announced in April that the reorganization of the CIUSSS de l'Estrie—CHUS would be completed in two phases; first the administrative functions would be restructured followed by a clinical reorganization early in 2016.

The PDG also announced during the videoconference that a performance management system would be developed by integrating the various performance models of the individual establishments. A senior manager from the CHUS, who did not choose replacement within the healthcare network, was appointed to lead the Transformation Support Office (TSO) until retirement in October. It was the responsibility of this director to develop the integrated performance model for the CIUSSS de l'Estrie — CHUS.

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[35] Loose translation: A citizen and an organization reinvented for life.
[36] Loose translation: In the Eastern Townships, together, innovate for life.
[37] information from the internal information bulletin Le Lien (20 avril 2015) and an article in La Tribune, appearing June 26th, 2015).

Following the videoconference, the vision was communicated to all members of the organization, as well as to other stakeholders within the community. Employees and stakeholders were polled to determine which three of six values proposed were best aligned with the organizational vision. Humanism, adaptability and engagement were the three that were chosen. With the finalized vision and the shared values identified, the newly created organization was beginning to take form. The organization, however, in order to ensure adequate communication to all members of the new entity maintained forum-style meetings within the previous establishments.

In April, at the forum for employees still physically located within one of the sites of the CHUS, the organizational structure chosen by the CIUSSS de l'Estrie—CHUS was presented. It was also communicated that the co-management model of the CHUS would be maintained in the new organization. While the organizational structure represented a more traditional and 'silo' logic for managing healthcare, it was indicated that the new organization would move to a more matrixed style of management through the introduction of patient trajectories. Managers were warned during the April forum that with the issuance of the ministerial guidelines for the first 100 days of the reform, changes would be announced and implemented very quickly with little time for consultation or negotiation.

The focus on transitioning the organization following the adoption of Bill 10 in February 2015, and on completing the creation of the integrated health centres following its implementation on April 1st, meant that the momentum of the deployment of daily continuous improvement in the three pilots within the CHUS slowed considerably.

Continued Deployment of SPCHUS Amidst Chaos and Uncertainty

The kick off for deployment of DCI in the second pilot, Medical Biology occurred in February, and was received with considerable enthusiasm from employees

of the services involved. Over the winter months, deployment in the pharmacy pilot continued with the introduction of daily caucuses (Stage 2 of deployment); Medical Biology and Medical Imagery continued their daily caucuses, improved problem resolution methods (Stage 3) and expanded DCI to other services within their programs (Stage 4). In addition, the first LEADS training session was conducted for all managers and supervisors involved in the three pilots.

Also of note during this period, Senior Management of the CHUS proceeded with the identification of five strategic operational indicators, as they had committed to doing in the meeting with representatives of the Planning and Deployment Team at the end of January. These five indicators, important for the alignment of daily continuous improvement activities to strategic organizational objectives, were determined during a fifteen-minute discussion at the end of a regularly scheduled management meeting on February 17th.

The indicators chosen were: conformity rates to POR's; satisfaction scores from patient experience surveys; variation to budget; average length of stay (DMS) in the emergency department; and overtime rates. While the indicators are not necessarily True North indicators, they do represent key areas requiring improvement within the organization. Given the amount of time spent on discussing the choice of key indicators, it is not surprising that there was some confusion following the management meeting on how the indicators would be used in the organization. Some members of the management team thought they would be used only in the pilots where DCI was being deployed, while other managers had understood that they would be used across the hospital. The indicators were introduced to the pilots over the period of February to April, and in each case a workshop was conducted with the client programs and services involved in the deployment to determine how they could contribute to improvement of the organizational indicators.

The Development and Planning team, following the indication by the PDG of the desire to integrate the various management models of the individual establishments, turned their attention to the integration of Planetree and Lean, in preparation of the restructuration to occur on April 1, 2015. Some preliminary work was done with another establishment within the Eastern Townships that was familiar with the Planetree model. The initiative was presented at the Steering Committee in March and the reaction of one of the committee members was unexpected. There was no question that members of the Development and Planning team would begin the integration of Planetree and Lean; this work would be managed at the strategic level of the organization, within the Transformation Support Office.

Several challenges with the deployment of DCI in the pilots were noted during committee meetings during this period. These included:

A. Lack of collaboration with the medical staff (while not having a formal hierarchical position within the services, the medical professionals were used to having an authoritative position providing direction to the various coordinators within the service);
B. Lack of commitment of the program co-managers to the deployment. The expectations in terms of changes to management practices and in terms of the deployment had not been clearly communicated to the program co-managers, making it difficult to find time in their agendas to advance the deployment;
C. Lack of organizational focus on the deployment given the uncertainty surrounding the reform. At the same time, there was pressure from the executive team to spend the money associated with lean phase II quickly as it was uncertain that the financing would be renewed;
D. A return to traditional management practices by managers given the stress associated with the upcoming reform.
E. Time-consuming pre-work (Stage 1 of deployment) prior to implementing visual management (Stage 2). As mentioned previously, 8 different elements had to be completed according to the deployment guide, before actual introducing visual management in the service. The theory covering the various elements included in the training sessions was felt to be too complex, and did not illustrate adequately the changes required to day to day management practices. Pilot participants echo this, indicating that the deployment was far more time consuming than expected.

In addition to these challenges, the members of the coaching cells were having trouble integrating the methodologies of lean, transformational leadership and patient experience in practice. It was noted by one team member that the concepts were layered one on top of the other, rather than integrated. The facilitation team members indicated that collaboration was difficult within the coaching cells that the roles of the various members were unclear, and that enacting the desired management paradigms was far from evident (especially the shift from being an expert to being a coach).

Several difficulties were also noted concerning the governance structure for the SPCHUS program. The link between the various instances was lacking. Despite the work done to integrate the various elements leading to the perception of SPCHUS as larger than DCI, the view was not shared by either the Executive or the Steering Committees. One senior manager commented that there was a difference between SPCHUS the project and SPCHUS the management system; the 'project' was under the responsibility of the Development and Planning team, while the 'management system' was perceived to be under the responsibility the director of the DQPEP. While the development and planning team saw SPCHUS as an integrated management system, actions by senior management gave the team the impression that the responsibility of the team was for developing and deploying DCI only (despite the role and responsibilities enumerated in Table 8).

The challenges encountered during the deployment from February to April 2015 reflect the uncertainty and lack of clear direction within the organization in the midst of a major structural reorganization. The committees questioned their role with the upcoming restructuration, and expectations of senior managers were unclear concerning the continued deployment in the pilots after April 1st. Hence, the Development and Planning team decided to concentrate on two elements: accelerating the deployments by transferring the responsibility for advancement to the client program managers; and positioning lean within an integrated performance model for the new organization. The decision for a more rapid deployment created some

resistance from the facilitation team members, as they did not feel that the key success factors existed. While the senior managers insisted that deployment should continue, this commitment was not felt in day-to-day actions (statutory meetings were frequently cancelled; expectations for deployment had not been communicated to the client program managers; and no changes were seen in the management practices of the senior leaders).

The planning and development team meeting in April focused on the deployment of SPCHUS to date. Participants reflected on the key learnings with the objective of suggesting adjustments to the deployment. During the meeting, members of the executive management team of the CIUSSS de l'Estrie—CHUS and the Transformation Support Office presented their expectations concerning the continued deployment of SPCHUS, and its perceived future within the CIUSSS de l'Estrie—CHUS. While they recognized that the transition was extremely difficult and was, at times, demotivating, they expected that efforts would continue to deploy DCI as quickly as possible at the operational level of the organization, as this level would be the least affected by the turbulence in the system caused by the adoption of the reform. The understanding of the importance of support and guidance from hierarchal superiors did not appear to be shared at the senior level of the organization.

In addition, the executive management team indicated that reflection concerning an integrated management system was underway at their level of the organization. Under the guidance of the director for the Transformation Support Office, representatives from organizations using a performance model such as lean, Planetree, Hôpital promoteur de santé and entreprise en santé met at the end of April to develop an integrated model, with the intention of presenting the proposed management system in early May. During the month of April, the director of the Transformation Support Office involved several of the professionals from the Facilitation Committee of SPCHUS in developing dimensions of this performance management system within the CIUSSS de l'Estrie — CHUS. The development of patient trajectories and the

implementation of an Obeya[38] were also underway. And, in parallel, the DRHCAJ reflected on the management competencies that would be required within the new organization.

While the management system was in development within the CIUSSS de l'Estrie—CHUS, the Development and Planning Team and the Facilitation Committee valiantly tried to continue with the deployment as requested. It was at this time that the ministry requested justification that the money invested in Lean phase II would bring about equal or greater savings in the short term[39]. This is the context in which the research participants proceeded with their reflection on key learnings and potential adjustments that could be made, or suggested, in the deployment of an integrated performance management system within the new organization.

1.2. Key Learnings from the First Action Research Cycle

In February 2015, a group discussion was held with the members of the Development and Planning Team to discuss the progress made in the deployment of SPCHUS. Nine of the team members were present for the discussion. The absent team members, in addition to all members of the facilitation team and three managers that had been intimately involved with the deployment of SPCHUS over the last year, were interviewed individually following the focus group (a total of nine interviews and one focus group with nine participants). The objective of the focus group and the semi-structured individual interviews was to circumscribe the key learnings concerning the development and the implementation of the performance management system. The interview guide may be found in Appendix D.

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[38] Obeya is a Japanese word that translates to "big room" in English. It has often been interpreted as the bridge of a ship, a war room, a command center or a brain. An Obeya is a collaborative environment where the critical indicators of the organization's performance are displayed, reviewed, discussed and acted upon by a multidisciplinary team.

[39] This was requested as part of the effort to position Lean within the reform; if a return on investment could be demonstrated, it was felt that the Minister would allow the investments to continue.

The group discussion and the individual interviews were transcribed and were analyzed in NVivo. Iterative cycles of analysis and memo writing followed the macro coding leading to the identification of the critical events and decisions, and the challenges facing the organization concerning the deployment of a management system. The analysis also provided a qualification of the progress made, and the identification of key learnings. The learnings that emerged from these iterative cycles of analysis, were then compared and contrasted to observations and field journal notes, leading to further refinement.

A summary of the analysis was presented to the Development and Planning Team in mid-April in the form of a PowerPoint presentation. The format of the presentation was based on a PDCA (plan-do-check-adjust) cycle, which is central to a lean management system. The narrative of the activities of planning from January to November of 2014 (plan) and of implementation from December 2014 to April 2015 (do) were presented. The results of the implementation were next reviewed (check). Finally, the analysis of the focus group discussion and the semi-structured interviews was presented with the objective of using the learnings to modify the introduction of SPCHUS and influence the development of an integrated management system in the Eastern Townships Integrated Health Network in the coming months (adjust).

1.2.1. Critical Decisions, Actions and Events

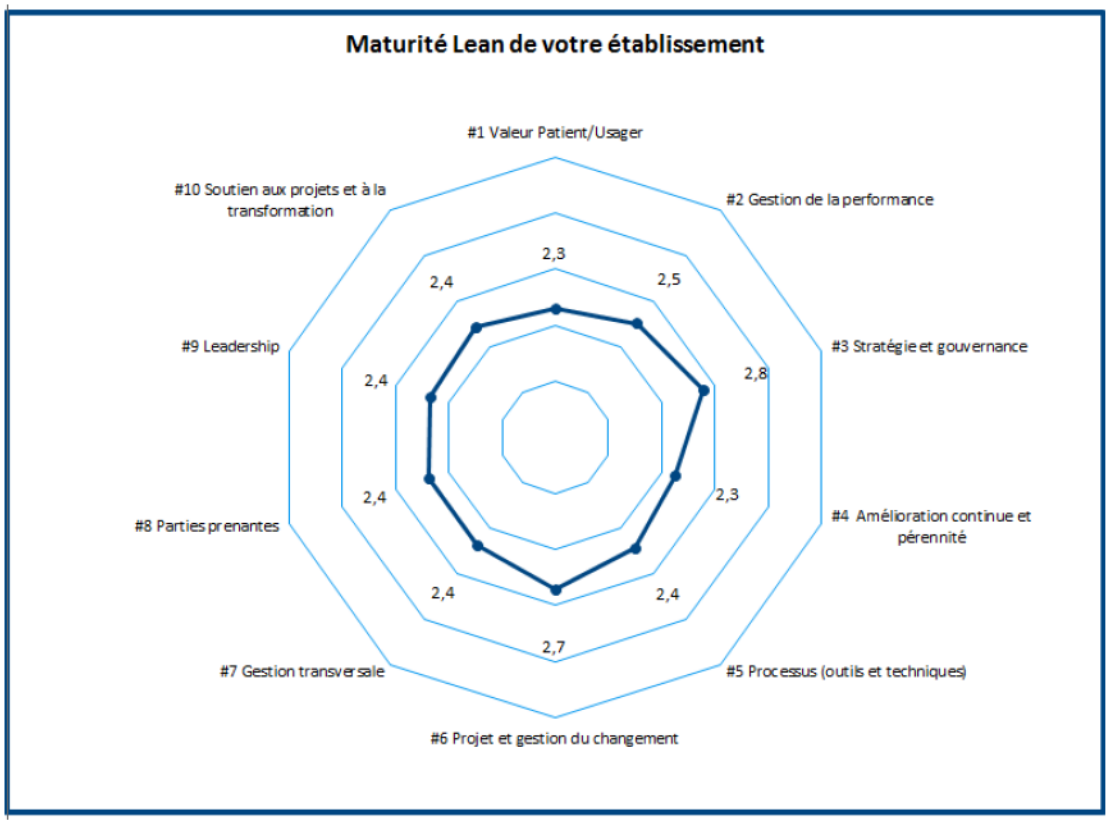
Several decisions and actions were identified by participants in the group discussion and the individual interviews as being key to the introduction of SPCHUS. Several internal and external events were also thought to be of great influence during the implementation. Their comments buttressed with field observations of events and decisions that impacted the introduction were used in to create the chronological summary presented Figure 7.

1.2.2. Qualification of the Progress Towards the Vision for SPCHUS

As you will remember from Chapter 1, and the description of at the beginning of this chapter, SPCHUS was presented to the MHSS as a cultural transformation. The Development and Planning Team translated their understanding of the required change into a change in management 'paradigms' presented in Table 9. The team also followed a multitude of performance indicators defined by the Ministry and several others determined internally. Progress on the implementation of elements of the program SPCHUS in terms of actions completed was also monitored, and lean maturity had been evaluated with the model proposed by the Ministry (and found in Figure 17).

Following approximately 15 months of development and deployment, the project plan had been 49% implemented and neither the indicators imposed by the Ministry (presented in section 1.1.1) nor those determined by the team (presented in section 1.1.5) had been met. The evaluation of lean maturity provided information on the current state as viewed by the Senior Management Team. Figure 18 provides a summary of their evaluation.

Figure 18
Evaluation of Lean Maturity of the CHUS by the Senior Management Team



Source: Internal presentation of the results compiled by the SME for SGIP

This radar diagram presents the average results of each of the dimensions on a scale of 1 to 5. In all areas, the CHUS evaluated their level of maturity as between two and three. The evaluation of the overall lean maturity of 12 of the 19 establishments funded under Lean Phase II was 2.5. M. Pierre Collerette, professor of management at the University of Quebec in Outaouais, indicated, at a meeting with lean experts from the 19 establishments that under three out of five reflects that the organization views lean as a project, while equal to or greater than a level of three indicates a view of lean as a culture.

The results based on the objective measures was discouraging for research participants. One key reason for the disappointing results, as discussed by the team and noted in the key learnings, was the lack of indicators measuring annual progress towards the finality, which was a long-term vision for the changes that would be seen

in the organization at the end of the three-year financing period of Lean Healthcare Phase II. The Development and Planning Team, while disappointed to see such minimal results in terms of the final indicators, reveal a more nuanced interpretation of the results, based on progress towards the desired finality of the transformational project SPCHUS and the desired changes in management 'paradigms.'

Looking first at the vision of the finality and the intention to organize around patient trajectories to improve the experience of patients, progress is perceived as minimal. While the organizational discourse includes talk of patient trajectories, there is little evidence of changes in the structure or management practices that favour the use of the trajectories in identifying priorities or in stimulating collaboration between sectors. As one participant mentions :

> De façon transversale, concernant l'amélioration des trajectoires patients, je crois qu'on n'est pas rendu au niveau d'une trajectoire encore, mais je sens que ça devient une nécessité de le faire. Comme par exemple, dans la dernière tournée de direction, les questions qui ont été soulevées par les gens de terrain qui essaient de résoudre des problèmes et qui là se rendent compte que ça a des impacts en amont, en aval de leur processus puis qu'ils doivent travailler en équipe avec d'autres secteurs[v]. (Professional)

Progress in terms of the use of continuous daily improvement is also seen as minimal.

> Amélioration continue au quotidien, moi je pense qu'il y a une meilleure conscientisation. On est encore dans une culture de projets plus que dans une culture d'amélioration continue. Bien qu'encore là, je pense qu'il y a une amélioration, mais je dirais qu'il en reste encore. Particulièrement par rapport au rôle du cadre sur le terrain. Quelle est sa responsabilité par rapport à ça ? Comment il se voit comme gestionnaire ? Comment il voit sa responsabilité par rapport à l'amélioration continue ? Ça je pense qu'on a encore un chemin à faire, mais c'est normal là[vi]. (Manager)

The change in management paradigms is difficult, and progress is qualified as non-linear with major steps forward followed by slightly smaller setbacks. This is felt to be perfectly natural, particularly when the change desired is for long-term results

and not for short term gains. The pressure and confusion in the period between the proposal of Bill 10, its adoption in February 2015, and implementation on April 1st was a particularly trying period for the organization in general, and more specifically for the implementation of SPCHUS. As one manager indicated: "quand on est sous pression, on revient vite dans nos vieilles pantoufles[40]." It is noted, however, that while the natural reflexes may return, there is evidence that some changes to the management paradigms are taking root. The following citation reveals a conscious effort and progress in moving from a project focus, to an operational focus, from micromanagement to managerial autonomy, and from experts to facilitator.

> Un peu moins le réflexe que toute question soulevée il n'y a qu'une méthode, c'est la gestion par projet : faire un projet, former un groupe. C'était comme la solution à tous les problèmes. Là il y a le coffre d'outils qui s'élargit je te dirais, parce que la croyance que tu peux, quand t'es à cet étage-là, dire au directeur bien nous ce qu'on veut c'est ça, puis on veut ceci pour cela ; mais les gens sont capables de trouver le moyen pour y arriver. Puis on l'a vu même dans les budgets quand on a eu des enjeux budgétaires ; les gens au lieu de bien regarder on va leur dire où couper ; non regarde, on va retourner chacun dans nos directions, on va aller voir notre monde et on va leur demander des solutions[vii]. (Director)

Progress is also noted in terms of how lean is viewed within the organization. As mentioned Lean was thought to be individually organized rapid improvement events and was not necessarily viewed in a positive manner, given its early history within the organization. As noted by one manager, « le mot Lean n'est plus tabou dans l'organisation et plus que ça, c'est plus englobant[41].» Also noted was a re-appropriation of the results in sectors where visual management and daily caucuses had been deployed. Employees understood how their daily actions influenced results in their area, and were motivated to resolve issues and improve performance.

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[40] Loose translation: when you are under pressure, we quickly return to our comfortable old slippers.
[41] Loose Translation: "the word Lean is no longer taboo in the organization and more than that it's more encompassing"

These pockets of appropriation and daily continuous improvement, while encouraging, were noted as not yet linked together, nor integrated at a senior level in the organization. As mentioned by an intermediate manager and member of the Development and Planning Team:

> Plusieurs petits ilots d'amélioration, de plus en plus, ici et là, et on comptait là-dessus qu'à un moment donné les ilots finissent par se toucher ; puis ça crée un continent, ça me donne cette impression-là. Mais la communication n'est pas encore si grande entre les îles, on ne se parle pas trop encore, on ne sait pas trop ce que l'autre fait. […] Je trouve qu'on avance de cette façon là[viii].

In qualifying the progress made towards the vision of SPCHUS, one element is identified as both a source of frustration and as a source of pride: the length of the delay between the beginning of conception to the actual deployment in the three pilots. It took approximately one year from the first meeting of the Development and planning team to the first official deployment. The frustration came from the amount of time spent clarifying SPCHUS, developing a common understanding at a theoretical level, and defining the deployment stages, versus time spent learning through experimentation. On the other hand, this time was thought to be necessary for the team to be able to move to the stage of experimentation and begin to change the management paradigms and practices:

> En tout cas, on a mis beaucoup, beaucoup, beaucoup de temps sur définir – pour essayer de se comprendre, définir c'est quoi le SPCHUS et qu'est-ce qu'on va faire et comment on va faire ça et ça ; ça a été long. Puis je te dirais qu'on est resté dans l'angle des concepts, on est resté beaucoup intellectuel. Donc, plus théorique[ix]. (Manager)

> Je pense que le principal c'est avoir développé des vocabulaires communs, avoir intégré les concepts. Ça a pris du temps un peu. Beaucoup de discussion par rapport à ça ; mais je trouve qu'on est vraiment passé de conception à intégration à mise en œuvre[x]. (Director)

The common understanding of SPCHUS developed within the Development and Planning Team and the Facilitation Team was believed to have a spillover effect on other initiatives in the organization, as the members worked in various groups on

other organizational projects and influenced perceptions concerning the desired management practices.

Overall the change embodied in the desired finality of SPCHUS, to the satisfaction of the group, was perceived to be taking root in the organization. A veteran of the health network for many years, an intermediate manager mentioned that there had been a lot of changes introduced over the years, but none seemed to penetrate within the organization as much as SPCHUS had. The changes were often introduced quickly in the hopes of obtaining quick results, and when they did not materialize another change was introduced. The manager indicated that with the time spent by the multidisciplinary Development and Planning team to think through, to discuss, to co-construct, and to develop the deployment plan for the management system were all factors that contributed to the positive progress. Unfortunately, the sustainability of the change was questioned given the context of the reform.

> Avec une certaine synergie […], il commençait à avoir — on n'a pas juste une recette, on n'a pas travaillé juste une série d'étapes — un plan d'action, on a travaillé des façons de penser, des modèles mentaux. Mais malheureusement, il y a eu un arrêt[xi]. (Manager)

> On ne peut pas dire qu'il n'est pas amorcé, mais nos leaders ne sont plus là pour continuer de favoriser cette intégration-là[xii]. (Manager)

1.2.3. Key Learnings

The initial analysis of the key learnings was presented to all interview participants in a meeting on April 17th, 2015, at the CHUS. Participants indicated that the presentation was a just representation of their experience. The opportunity to take a step back, to look globally at the events over the last year, and to ultimately learn from this was greatly appreciated by the group. Based on the feedback from the participants, and further iterations of analysis and memo writing, the learnings were refined and are presented here.

Understanding of SPCHUS: a Project or a Transformation?

What SPCHUS represents for the organization is different for diverse hierarchal levels of the organization. Over the course of the planning phase, evolution in the

understanding of SPCHUS was notable for the Development and Planning Team. This understanding, however, was not shared at the senior management level. The team's understanding of the role entrusted to them was to conceive of and suggest a deployment strategy for all five of the elements of SPCHUS. This was reflected in the role and responsibilities as presented in Table 8. At the senior level of the organization, it was tacitly understood that the role entrusted was for the deployment of Daily Continuous Improvement only. This perception is supported by the surprise of the directors (noted during interviews) in the scope of the work taken on by the Development and Planning team.

In addition, SPCHUS was thought to be, by many members of the organization, a project rather than an organizational transformation. While it was considered extremely important to the organization, as reflected by its inclusion in the top five organizational projects, it was managed as a project and not as an integrated performance management system meant to bring about cultural change.

> Les ressources ont été allouées. […] SPCHUS c'est un projet hyper transversal. Peut-être les difficultés qu'on a eues étaient un peu plus comme je disais tantôt ; de dire oui [cette personne est] un expert. Elle avait quand même l'agrément à s'occuper. Je veux dire, on a des opérations, même si on dit qu'on n'a pas d'opérations on a une direction, beaucoup de soutien, mais n'empêche qu'on a des objectifs à atteindre et c'est sûr que c'est la même chose pour [l'autre personne] à l'évaluation de l'expérience patient, il fallait que ça se fasse puis ce n'était pas nécessairement dans SPCHUS[xiii]. (Director)
> Je dirais, avec le recul, comment ce n'était pas vraiment très clair la vision, les finalités précises. Et que moi, pour avoir travaillé dans le déploiement SPCHUS, comment voit-on même encore jusqu'à aujourd'hui, c'est quoi la finalité, c'est quoi le livrable ? Là-dessus, je dirais qu'on est un petit peu en dehors de la track[xiv] (Manager)

The positioning of SPCHUS as a project was evident in the governance structure, typical of a traditional model of project management, and common within the organization.

> Le fait d'avoir géré SPCHUS comme un projet […] ça ne marche pas dans le sens que déployer une culture ça prend des années, ce n'est pas quelque chose qui a une fin[xv]. (Professional)

> On sait qu'on l'a mis en projet, mais ce n'est pas le projet où il y a : un projet, un début et une fin. SPCHUS n'a pas de début ou de fin. Ce n'est pas comme d'installer une IRM, où t'as un début, une fin et des ressources à allouer ; et bon tu y vas. Tandis que ça, c'est un changement de culture : c'est l'intégration[xvi]. (Manager)

The discrepancy in understanding of the meaning of SPCHUS may explain the role that the most senior managers played in its development and deployment. This critical role will be discussed next.

The Crucial Role of Senior Managers

As one of the coaches of the deployment noted, "on accompagne des gens à se transformer. J'ai appris qu'il faut que ça commence par nous."[42] Changes in management practices of the senior leaders in the organization was not evident to the research participants. The level of priority of the deployment of SPCHUS, and the expectations of changes to management practices was not communicated to the program managers of the pilots. The lack of implication at this level made the deployment difficult.

> Il y a tout aussi l'implication de la ligne hiérarchique qui est nécessaire, qui est fondamentale et qu'on doit transformer[xvii]. (Manager)

> … mais leur chef, leur directeur ; ils ne sont plus là et ça, je l'ai vécu. [Les supérieurs hiérarchiques] ne les avaient pas vraiment informés. Ça a été difficile[xviii]. (Manager)

As noted in the narrative, the announcement, adoption and implementation of the reform did turn much of the attention away from the deployment of SPCHUS. It is, however, important to note that from the beginning, as early as the kick-off in June, organizational members perceived that the target of change was the intermediate level

[42] Loose Translation: "we accompany people in their personal transformation. I have learned that in order to do this, transformation must start with us".

managers and that senior managers were somehow outside of the change. While senior level managers were responsive to requests from the tactical team to provide support for SPCHUS, for example by determining 'True North' indicators, or by introducing SPCHUS during deployment in the pilots, unfortunately, there were few notable changes in their day-to-day management practices.

Integration of the principal elements of the performance management system, and their role in facilitating achievement of the vision expressed, is generally thought to be the responsibility of the most senior managers of an organization. The lack of integration and difficulty in collaboration at the strategic level of the CHUS was highlighted by the team as the third learning.

The Importance of Integration and Collaboration

Efforts at the integration of the concepts into a performance management system were perceived to have occurred at the tactical level of the organization, and not at the senior management level. One of the possible explanations for this provided by the research participants was the absence of other senior managers in the development and deployment of SPCHUS. The Steering Committee included only four directors, and only one director was involved in the Development and Planning Team; hence, there was not a common understanding of SPCHUS that was shared at the highest level of the organization.

> Je pense, avec le recul, que les directeurs, est-ce la priorité ? Ça aurait été bon qu'il y ait un autre directeur pour favoriser une pression pour l'action, le mouvement, attacher, favoriser les liens, faire atterrir ça. Je pense, parce qu'on dit toujours oui ; je pense que ça, ça aurait été bon[xix]. (Manager)

> Il n'y a pas d'appropriation de nos principaux acteurs concernés, mais une personne, un directeur qui le porte réellement[xx]. (Manager)

This lack of a shared understanding of SPCHUS manifested itself in a lack of integration of various organizational elements and difficulties with collaboration. In terms of integration, many directors viewed SPCHUS as an initiative led by the DISC.

It was viewed as a transversal organizational priority to be implemented alongside the functional objectives of each department. Difficulties arose then in determining how to allocate resources and continue to meet both the functional objectives and the organizational objective of SPCHUS.

> Ce n'est pas parce que, comme je disais, pas parce qu'il y a SPCHUS qu'on ne fait plus d'évaluation de l'expérience patient. On en fait depuis 2008 et on va continuer à en faire. Donc, comment on harmonise le fait qu'on a quand même des objectifs de direction avec quelque chose qui est plus transversal ? Il y a un apprentissage à faire là-dedans[xxi]. (Director)

Meanwhile, members of the Development and Planning Team, representing various functions of the organization, learned throughout the process of development to view SPCHUS as an integrated system, and to understand that its deployment required close collaboration between the various functions. It also required a holistic view of the process and how the various services of a program contributed overall to the continuum of patient care. This transversal view and collaborative mode of functioning were new to the organization, and difficult to learn. As one director explained:

> Dans les apprentissages, je pense que je vois des initiatives d'apprentissage de gestion matricielle. Justement parce que je courtise les collègues directeurs. Ça aurait été difficile d'en arriver là si principalement le DISC, le DRHE puis le DQPEP n'avaient pas lâché certains éléments de culture de gestion. Avant, ils étaient très « décisions » : par cette prise de position, cette décision-là appartient à cette direction-là, celle-là à celle-ci et celle à l'autre, etc. Vous voyez trois colonnes. C'est certain qu'il y a beaucoup de travail fait ici, autour de la table — partage d'expertise, de la compréhension de l'expertise, mais en même temps, ça demande à l'autre étage de commencer à faire de la gestion matricielle. Je ne peux pas tout vous dire, mais c'est loin d'être facile. C'est un apprentissage qui est fait là en partie ; mais sur lequel on a besoin de continuer à travailler[xxii].

The learning is judged, however, to be extremely important for the organization. Creating a matrix organization structured around patient trajectories,

requiring collaboration is an opportunity to build upon with the implementation of the reform.

> J'ai comme un espoir que l'organisation en tire l'apprentissage que pour transformer puis amener cette transformation-là. Puis en même temps il y a une opportunité à saisir avec la loi 10. Mais de modifier une structure qui permet de gérer des trajectoires, travailler en équipe et mettre des gestionnaires dans la trajectoire et lâcher le silo ; favoriser cette cascade-là[xxiii]. (Professional)

Importance of Identifying Interim Objectives

The final learning highlighted by the research participants was the importance of identifying interim objectives. During the group discussion, and presentation of the initial analysis of the learnings from the individual interviews, it was apparent the participants were disappointed by the lack of achievements versus the indicators that had been identified. The team realized that while they had identified indicators for the achievement of the long-term objective, they had not specified shorter term, annual objectives to measure specific milestones. Part of the reason for the lack of indicators, as noted by one participant, was due to the fact that it was not clear what the objective of SPCHUS in fact was.

> Je dirais, avec le recul, comment ce n'était pas très clair la vision, les finalités précises. Puis que moi pour avoir travaillé dans le déploiement SPCHUS, combien tu vois encore, même jusqu'à aujourd'hui, qu'est-ce que la vision, c'est quoi la finalité, c'est quoi le livrable ? Là-dessus je dirais qu'on est un petit peu en dehors de la track. Mais on perd beaucoup d'énergie à essayer de rendre ça concret, d'être dans l'action[xxiv]. (Manager)

1.2.4. Challenges, Priority Level, and Motivation

The intention and the desire of the Senior Management Team to continue with the deployment was unquestionable; the context, however, made it extremely difficult for them to invest the time and energy necessary to support its implementation as their focus was turned towards the creation of the new organization. This lack of support

created a lack of engagement of the facilitators as indicated by a member of the Facilitation Team.

> Bien la démobilisation des équipes, par le temps que ça peut prendre pour arrimer toute cette cascade-là. Parce qu'il y a une limite à ce que l'amélioration continue au quotidien soit portée juste par le terrain. Ce n'est pas vrai qu'il y a juste eux qui ont des actions à faire pour améliorer les choses[xxv]. (Professional)

This lack of engagement was echoed throughout the organization. As the entire organizational structure was in metamorphosis, and managers had no idea what their role would be in the future, there was neither interest nor incentive to continue with the deployment of SPCHUS. In addition, there was concern that the advancements made by the CHUS in understanding and implementing an integrated management system inspired by a lean philosophy would be lost within the new organization. The temporary status of key resources with lean experience was also cited as a challenge and cause for concern. The professional resources had been hired shortly after the CHUS began implementing kaizens as an improvement tool. The investment in hiring the resources was justified by the savings that the kaizens generated for the organization. Their temporary status had never been modified, and it was not certain that the continued implementation of the integrated performance management system would be a priority for the organization. The organization faced a risk of losing valuable resources over the interim period.

And finally, how would the apparent short-term focus within the health network affect the development of an integrated management system in the CIUSSS de l'Estrie — CHUS ? The implementation of such a system produces results over several years; embarking on the development and deployment is not for short term gains.

1.2.5. Suggested Adjustments to the Deployment

Although the participants indicated that the presentation of the narrative of events, and of the learnings were a just representation of their experience, many of their comments focused on explaining and justifying the results, rather than on suggesting potential modifications to improve the deployment. It should also be noted that

confusion on how to proceed, given the expectation of senior managers to continue deployment without their involvement, was palpable. The belief in the possibility of an integrated management system, such as SPCHUS, to considerably change management practices and ultimately organizational performance was strong. In contrast, the feasibility of continuing in the context was questioned extensively.

The proposed adjustments, based on the learnings, centred around two themes: a) actions required to continue deployment in the three pilots at the CHUS, and b) suggestions for the conception and deployment of an integrated management system for the CIUSSS de l'Estrie — CHUS.

First and foremost, the team requested that the expectations of Senior Management concerning continued deployment of SPCHUS be clarified and communicated to the managers and supervisors within each of the three pilots. The team also committed to creating short term objectives and goals to measure progress, and to validating these with the program co-managers. Coaching would continue within the pilots, and the deployment of visual management and daily caucuses would be expanded to other services within the programs. The team also decided to define the desired management paradigms in terms of expected behaviours, making the desired change more concrete and less theoretical. In addition, the facilitators undertook a simplification of the deployment guide, reducing the time necessary from theoretical training to experimenting and learning in action. The proposed simplification would reduce the deployment time from 30 weeks to 15 weeks.

Secondly, the Development and Planning Team strongly recommended that the governance of an integrated management system be integrated into the functional operational structure of the new organization. It was suggested that discussions concerning the vision of such a system, and of its deployment occur at the most senior levels. The use of patient trajectories to identify the areas in which daily continuous improvement should be deployed was also recommended. And finally, the importance

of role modelling by senior leaders was highlighted as a critical success factor for the adoption of an integrated management system in the CIUSSS de l'Estrie — CHUS.

These recommendations were not arrived at easily. Several emotionally charged meetings were held over the months of April and May 2015, illustrating the discomfort in continuing deployment given the absence of several critical success factors, most importantly the lack of support and role modelling from superiors. It was also very difficult for participants to suggest ideas on how to continue deployment instead of indicating the reasons why it was not possible under the current conditions.

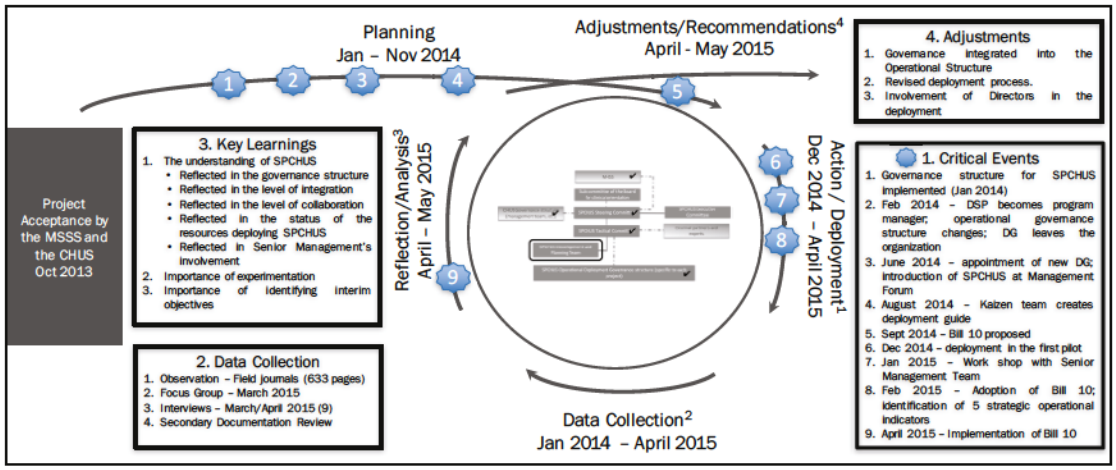
1.3. Summary of the First Action Cycle

A schematic summary of the first action cycle, presented in Figure 19, includes the critical events, key learnings and suggested modifications to deployment. While the results of the performance indicators demonstrated little progress, the participants indicated qualitatively some satisfaction with advancement. SPCHUS represented a transformational change for the Development and Planning Team, and considerable efforts were made at integrating its five dimensions. Evidence of moving away from a silo-based management style at certain levels of the organization was exhibited, and slight movement from actual to desired management practices may be observed in isolated areas within the hospital. Continued progress, however, was slowed with the announcement of Bill 10 in September of 2014, its adoption in February 2015, and its implementation on April 1st, greatly affecting the progress of deployment.

Central to the learnings of the first cycle is the understanding of organizational members at various hierarchal levels of SPCHUS. The understanding of what it was is reflected in the governance structure, the level of integration of its dimensions, the collaboration between various departments and the level of involvement by the Senior Management Team. Also notable is the tendency to manage all activities in the organization as a project, separating the project into specific lots to be managed independently.

The key learnings were communicated to the interim director of the Transformation Support Office, and were incorporated into the continued deployment of SPCHUS within the hospital.

Figure 19
Summary of the First Action Cycle



1.4. Narrative of the Second Action Learning Cycle

As will be seen in the narrative of the second cycle, the integrated management system for the CIUSSS de l'Estrie—CHUS was not defined at the beginning of the cycle. The system was developed over several months, with a formal governance structure introduced in the fall of 2015, followed by a definition of the vision in early 2016. Over this period, the researcher was involved in the initial stages of development with a small group within the Direction of Quality Management, Performance Evaluation and Ethics (DQÉPÉ) and participated in the various committees in the governance structure introduced later. During this cycle, the researcher also assisted in several small cycles of analysis and reflection, providing feedback to the organization throughout the process. These are presented throughout the narrative and visually in the timeline in Figure 7.

1.4.1. Implementation of a Management System from Above (May - June 2015)

Structuration of the CIUSSS de l'Estrie— CHUS

By May 2015, the CIUSSS de l'Estrie—CHUS implemented a temporary management structure (by regional zones) until the final organizational structure was fully functional. Hiring for most of the senior managers was completed, including the appointment of the director of the DQÉPÉ, and the hiring process was underway for the assistant managers in the administrative sectors. While the newly appointed director would have the responsibility for the continued development and implementation of the integrated performance management system, and for the Transformation Support Office, it continued to be led by the interim director until the end of October. The initial organizational structure for the DQÉPÉ was communicated in early June.

By the end of June, all the senior managers were nominated along with many of the intermediate level managers (78 positions). Employees began reporting to the managers of the CIUSSS de l'Estrie—CHUS and no longer to the person that was their superior prior to the reform. For the clinical functions, the temporary structure with zones, was maintained as the clinical functions would be reorganized following the completion of the administrative reorganization. During the month, the PDG communicated to the organization the principal elements of the management philosophy via the weekly information bulletin, Le Lien. The key elements included the development of a performance evaluation model to continuously improve daily operations; a focus on developing leadership competencies (coaching, communication, interpersonal relations, employee development, and inspiring teams to meet their goals); decentralization of decision-making; and integrating the voice of the service users in improvements to the delivery of care and services.

The progress the organization made in the first 100 days was notable. The accomplishments, noted with a great deal of pride by the PDG, included:

A. Giving sense to the transformation through the development of a vision, a principle of action (coherence), values and a management philosophy (see appendix F);
B. The executive management team toured various installations to meet employees, to listen to and to address their preoccupation;
C. Communication tools were developed to provide information to the entire organizational community concerning the transformation;
D. The senior management structure was completed with the nomination of 48 senior managers, below the maximum specified by the MHSS to favour the decentralization of decision-making with an increased number of intermediate managers;
E. 78 intermediate managers were hired;
F. Professional councils (nurses, doctors and pharmacists) were in the process of being formed, and an integrated user committee was formed;
G. Six patient trajectories were identified, and nominations of 4 of 6 medical co-managers for the trajectories were completed;
H. Several best practices were identified and would be explored for improving efficiency and performance across the organization.

At a conference call of the lean experts for each of the 19 establishments financed as part of Lean Phase II at the end of June, it was announced that the Ministry would continue their financing, and that the action plans developed in each of the 19 individual establishments were to be updated to reflect how lean deployment would be adapted to the integrated health centres. Several of the 19 establishments indicated difficulties in continuing the advancement with lean deployment given the high level of ambiguity generated with the reform. The fusion of establishments familiar with lean and those less familiar naturally meant that deployment had slowed across the healthcare network. During the transition, the experts agreed that it would be important to show how lean could positively support the reorganization, however, the approach should be integrated with organizational development efforts, leadership skills development, and change management initiatives. During the call, it was noted that a strategic Obeya would be used at the Ministry and it was expected that all the integrated health networks would implement Obeyas to evaluate and manage performance[43].

[43] The CHUS had implemented a strategic Obeya prior to the reform, based on a benchmark visit to Thedacare.

As the major structural changes required to establish the new integrated organization were being implemented (according to the book of guidelines issued by the Ministry for the first 100 days of the reform), and direction was being provided by the MHSS concerning their expectations concerning Lean, the Transformation Support Office interim director orchestrated the continued development of several key elements of a management system.

The first element of the system, the performance evaluation model, proposed in April by the team that had experience with the various models of the individual establishments, was adopted in May. The performance model would undergo several modifications between its introduction and the final version that was issued in late fall. Figure 20 presents the final version.

Figure 20
Performance Evaluation Model

Source: Internal document used to present the performance management model to organizational members.

The visual representation includes the vision of the CIUSSS de l'Estrie—CHUS, loosely translated as "In the Eastern Townships, together, let's innovate for life" (the orange banner at the bottom of the schematic) and the shared values of adaptability, humanism and engagement (inner green circle). The organization is positioned within the territorial network (dark green outer circle in the schematic), with the ultimate goal of providing the patient, their families and the population accessible quality care and services (the inner gear of the diagram). The integration of the academic mission, the judicious use of resources, and the collaboration of employees,

doctors, managers, partners, volunteers and the community facilitate the fulfillment of this mission. These elements are depicted as the outer gears, representing the idea that all are necessary; if one gear stops, all others will stop and the organization will not be able to fulfill their mission.

The second element of the system introduced, concerned how work processes would be coordinated. The Executive Team[44], in consultation with the interim director of the Transformation Support Office decided that services in the new organization would be structured around patient trajectories with the objective of improving accessibility, fluidity and efficiency of healthcare service delivery. In mid-May, Alain Rondeau[45], Honorary Professor at the HEC, Director of CÉTO and Associate Director of Pole Santé, provided training on how to organize around trajectories to the senior managers that had been appointed at that time. As several positions were still being filled, the training was taped, and the training capsules were then used to train all senior managers and intermediate managers at the end of June.

The third element, a strategic Obeya was installed in June. It was organized around the 'ambidextrous' management of priorities in maintaining operations while at the same time completing the fusion of the 14 establishments and the regional health agency into an integrated health centre. Ambidextrous management, a concept that was introduced by Alain Rondeau, refers to the capacity of an organization to manage two challenges that appear contradictory. For the CIUSSS de l'Estrie—CHUS, the challenge was to manage the critical projects required to transform[46] the organization,

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[44] The Executive Team at this time included the PDG, the PDGA, the DGAs, and the Directors of the DFRL, DQÉPÉ, DRHCAJ and the direction administratif de recherche (DAR)

[45] Alain Rondeau provided guidance to the CHUS senior management team when they were implementing their balanced scorecard approach to performance management. He continued to provide training and counselling to the CIUSSS de l'Estrie – CHUS given his expertise in the principles and success factors of matrixed/collaborative forms of organization

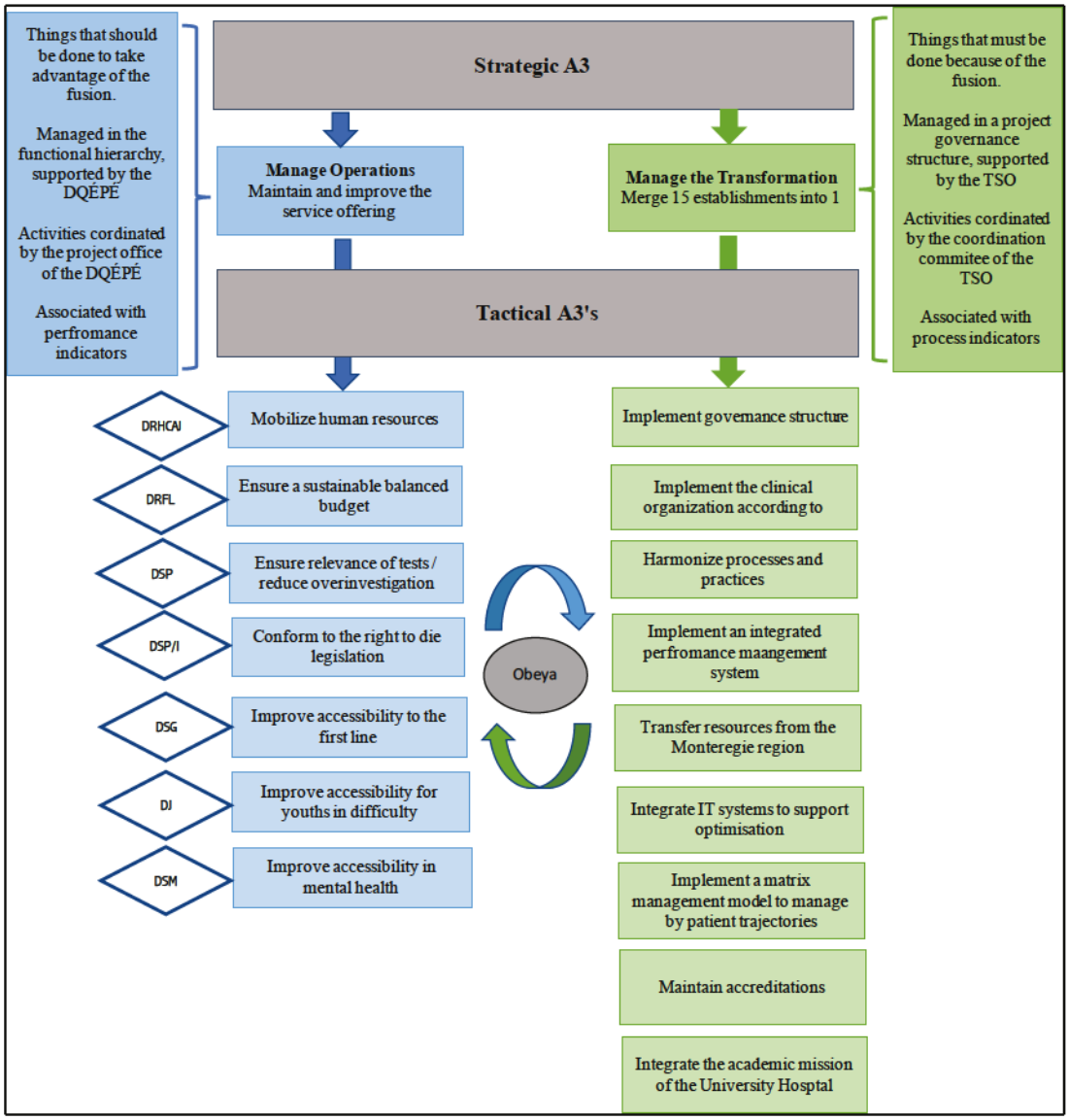
[46] Note that the CIUSSS de l'Estrie – CHUS speaks of the fusion of the 14 establishments and the regional health agency as a transformation. Pierre Collerette, honorary professor of management at the University of Quebec in Outauais, refers to the period of implementing the new structure as a transition. Transformation presupposes a second order change (Watzlawick *et al.*, 2000), involving changes to mental models (paradigms).

while at the same time managing daily operations and maintaining the quality and security of healthcare services. The intention of the organization was to move away from a project management focus towards a focus on operational management. As we will see throughout the narrative, this is a struggle the organization continued to try and overcome throughout the period of this research study.

The priorities to be monitored in the strategic Obeya were identified in the Strategic A3 completed by the PDG and members of the Executive Team. An A3 is a tool which had been used by the CHUS. When used appropriately, it is a process by which an organization identifies, evaluates, acts and reviews progress on problems, projects and priorities. It is a methodology that facilitates learning, and allows for coaching and mentoring a standard problem-solving method (Shook, 2008). In the case of the CHUS, the A3 tool was implemented following a benchmark visit to Thedacare, and was used by the organization as a tool to record pertinent information around a problem or priority, and document an action plan. This is also how A3s were used in the CIUSSS de l'Estrie — CHUS.

The strategic A3 included an analysis of the context of fusion, and the vision for the future of the organization. Specific initiatives were identified to manage the period of transformation and to improve organizational effectiveness. From the actions identified, several were considered to be critical priorities. Figure 21 schematically represents the notion of ambidextrous management, with the organizational priorities classified as either an operational priority or a transformational priority.

Figure 21
Ambidextrous Management of Organizational Priorities of the CIUSSS de l'Estrie—CHUS



Adapted from internal documentation describing the ambidextrous management

For each of the priorities a strategic sponsor (executive management member), and a project owner at the tactical level (senior manager) was identified. It was expected that each senior manager would meet with the appropriate people to complete the A3s over the summer period. As many of the managers were unfamiliar with the use of A3s, professionals within the DQÉPÉ were assigned to support the teams

responsible for their completion. As can be seen in the figure above, one of the 19 transformational priorities identified was the development and implementation of an integrated performance management system, identified by the organization as SGIP (système de gestion intégré de la performance).

Transition from SPCHUS to SGIP

In parallel to the structuration of the new organization, the Deployment and Planning Team for SPCHUS continued their efforts to adjust the deployment plan given the learnings and the expectation that the deployment be accelerated. As mentioned in the previous section, the team experienced a certain amount of dysfunction during the process. Despite this, the team did provide a modified deployment plan and recommendations for the development of a management system for the new organization. These were the last activities related to SPCHUS, as members of the Development and Planning team and the Facilitation Committee became more involved with the interim director of the Transformation Support Office in implementing the elements of the management system for the CIUSSS de l'Estrie — CHUS.

At the end of June, the researcher met with the interim director of the Transformation Support Office to discuss the next steps of development for SGIP with an interest in how to ensure that the learnings from SPCHUS were transferred to those that would be responsible for SGIP. One of the key learnings concerned the importance of a shared understanding of the meaning of an integrated management system, and the necessity to integrate the various dimensions. At this point in time, patient trajectories, one of the organizational priorities was the responsibility of the DGAs, the development of leadership competencies the responsibility of the DRHCAJ. Each of the A3s was assigned to a specific function for completion. It was also noted that the distinction between the responsibilities of the Transformation Support Office for managing the transformational projects, and DRHCAJ and their responsibility for organizational development was unclear. It is interesting to note that the interim

director indicated that these learnings would be important to include in the A3 concerning SGIP, to be addressed by the director of the DQÉPÉ. This reflects an ongoing understanding of SGIP as DCI, and the parcelling of elements of an integrated management system into specific 'lots' under the responsibility of various specific functions.

1.4.2. Management of Organizational Priorities (July - September 2015)

Attempting to Create Organizational Focus during a "Wild and Woolly" Period

The second book of guidelines for the upcoming 100 days was issued by the Ministry in July. As the organization worked to ensure compliance with the guidelines, the newly appointed managers familiarized themselves with their role in the new organization. Managers had lost all their previous points of reference and had an imprecise understanding of their role and responsibilities. This period was described by one director as "fou et flou[47]." In parallel to organizational members working through this confusing period, and attempting to make sense of and advance the organizational priorities, the CIUSSS de l'Estrie—CHUS announced their plan to meet the financial targets imposed by the Ministry for 2015–2016. The organization indicated that they would reduce expenses by $30 million; $17 million through the administrative restructuring, $8 million though improvements in the relevance of certain care and services offered, $2 million through improved purchasing agreements, and another $3 million in improvements in miscellaneous operating expenses[48].

Also during this period, an impressive amount of time, energy and resources were invested in mapping the six trajectories identified by the executive management team. Service users, socioeconomic partners, professionals, doctors and managers worked diligently to understand and visually represent the patient pathways and

[47] Loose translation: "wild and woolly" or "crazy and confusing".
[48] Source: Le lien, le 2 juillet, 2015

understand issues and challenges facing service users. This understanding was then used by the senior managers to develop their clinical organizational charts. The managers worked within their specific functional departments to propose the organization of clinical activities that would best fit with the patient trajectories. The proposed clinical organizations, developed in approximately three weeks without consultation between trajectories nor with employees within the trajectories, were then presented to all senior managers for discussion and approval in early fall.

In September, facilitation of the Obeya, using the model of ambidextrous management, began. The integration and coordination of the 19 priorities fell under the responsibility of the Transformation Support Office. A professional, a member of the DQÉPÉ, was responsible for coordinating and integrating the actions identified in the A3s, and for presenting any issues or challenges to the executive management team. A process was developed for the integration and communication of progress on the priorities during the animation of the Obeya which would occur every two weeks, alternating between the operational and transformational priorities on a bi-weekly basis.

Every four weeks, transformational priorities would be the focus of the strategic Obeya. Participants included the Executive team, and members of the Transformational Support Office. Members of the Support Office presented to the executive management team a summary of progress for all of the transformational A3s, and the risks, challenges and obstacles to completing the projects. Decisions were made in terms of coordination of the activities and actions to be taken to counter the risks and remove obstacles. Following the meeting, the decisions were communicated back to the A3 owners (as mentioned previously, these were managers at the tactical level of the organization responsible for the transformational priority). The owners were sometimes in attendance to explain in more detail specific elements of the priority; they were not, however, involved in the decision-making discussions.

Review of the operational priorities was also planned every four weeks (staggered by two weeks from the transformational priorities), and participants were the members of the Executive Management Team. At this review, the strategic sponsor of the operational A3s, presented a summary of progress, and indicated any support required for the advancement of the action plans. The management team, following the review, decided on the appropriate actions which were then fed back to the tactical owners. These two processes were schematized and are presented in Figure 22 and Figure 23.

Figure 22: A3 Process for Transformational Projects

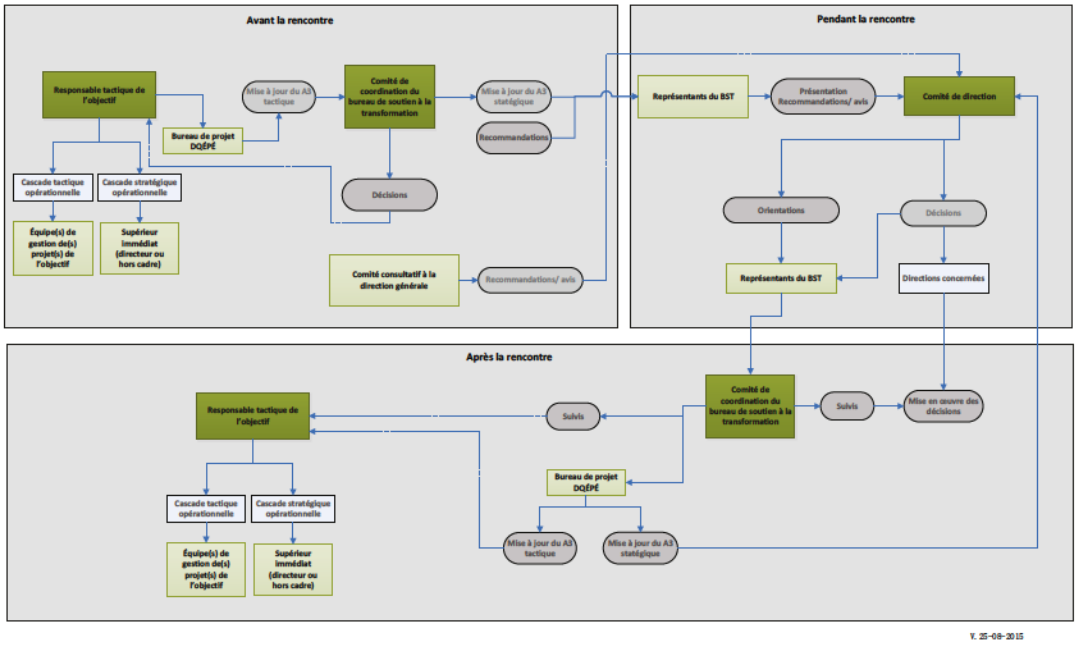
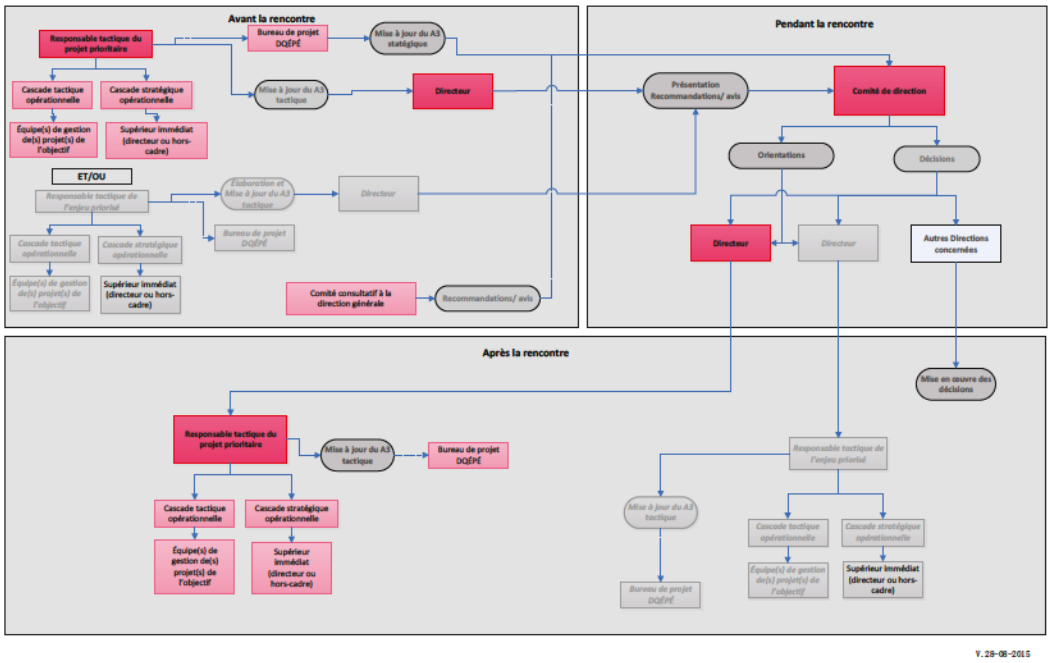


Figure 23: A3 Process for Operational Priorities



The details of each of these processes are not important for the reader to understand but are presented to highlight the level of sophistication in the conception of the organizational processes that were developed in order to manage the work to advance organizational priorities.

Conceptualization of SGIP

The DQÉPÉ Director, the assistant manager responsible for organizational performance and evaluation and optimization (DAEPO), a professional in the DAEPO (the SME for SPCHUS), and the researcher met for the first time in July to discuss the introduction of an integrated performance management system. The objective of SGIP, as mentioned in the title of the A3, was to transform the organizational culture. The executive sponsor for this A3 was the PDGA. The central point of the first meeting was familiarization with the work done on the development and introduction of SPCHUS. Focus then turned to the overlap and duplication found in the various A3 priorities currently being worked on by separate groups in the organization.

During July and August 2015, several other meetings were held to continue the development of the A3 concerning the integrated performance management system. There was some pressure to complete as quickly as possible the A3 as the priorities that were being treated through A3 analysis were to be presented to the Executive Management Team in early September for approval, following which, the coordination of the various activities of the priorities would begin.

The critical importance of having the involvement of the Executive sponsor in the development of the system was mentioned at the first meeting of the A3 team concerned with SGIP. Despite this, the work continued with only the involvement of the assistant director of the DAEPO and the SME.

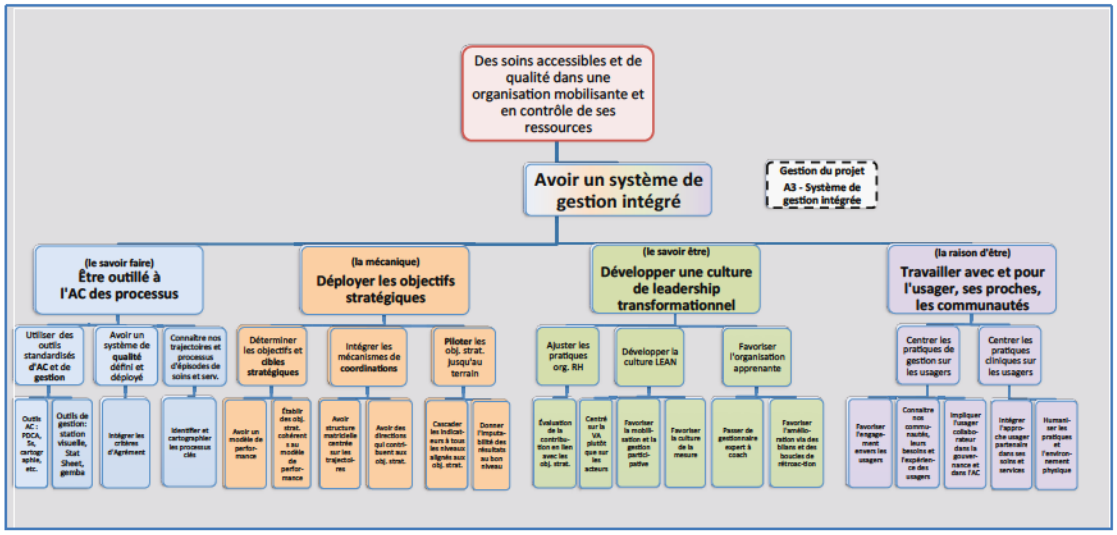
The dialogue concerning the development of SGIP centred around the distinction between a performance model for evaluating performance, which had been previously developed, and an integrated performance management system. This was considered critical and was included in the A3 analysis as a risk for SGIP. To address this, the SME, and the researcher, developed a proposition concerning the distinction between the two[49], and suggested a process for integrating the identified priorities based on an analysis of the key performance indicators tied to each of the performance elements defined in the evaluation model (a process based on strategy deployment found in Lean management systems).

The SME informally met with other professionals in the performance service to discuss the possibility of integrating the various priorities, based on the proposed process. For example, the process was presented to the professional responsible for

[49] The definition of a management system provided to the organization was the following: "A system can be defined as a composite of interlinked process that function harmoniously, share the same human, material, information, infrastructure and financial resources, and are all directed towards the achievement of set goals (policies, objectives and targets). […] It is important to note that the systems approach conceptualizes an organization (…) as a single system, rather than as a set of independent function-specific management and operational systems." (Jonker & Karapetrovic, 2004, p. 612).

visual performance management at the strategic level (the strategic Obeya), to highlight how visual management and SGIP were related, and how they could be integrated and deployed in a cohesive manager. The visual schematic (see Figure 24 below) of the understanding of the integrated performance management system was updated at this point to reflect the understanding of the very small group of people responsible for completing the A3 for SGIP.

Figure 24
Schema of SGIP



Source: Internal document created by the SME of SGIP

The schematic reveals the evolution in the understanding of SGIP as a system that englobes the tools of continuous improvement, the deployment of key indicators, the behaviours and attitudes expected of managers, and the central focus on working for and with service users, their families, and the community.

In August 2015, an action plan for the development of an integrated management system was proposed via the A3 tool. The main elements of the plan included the implementation of a governance structure integrated in the operating structure of the organization, appropriation of the essential elements of the system by the Executive Management Team, integration of the system in the daily activities of executive and senior managers, development of a training plan and deployment

scenario, and development of a communication plan for the system. These activities were to occur between the months of September to December of 2015. As will be seen in the narrative of this period, most activities were centred around preparing for the clinical reorganization, with the result that the plan was not discussed with the sponsor of the A3 (the PDGA) until much later in the year.

At the end of August, the interim director of the Transformation Support Office and the project lead for the patient trajectories requested support from the SME of SGIP and the researcher to conduct interviews with the executives, directors, and the senior managers (with their medical co-manager where appropriate) in order to facilitate their reflection concerning the next steps required to move from mapping to managing patient trajectories. The researcher and the SME profited from this opportunity to integrate additional questions regarding their understanding of SGIP. The interview guide (see Appendix D) was prepared by the organization, and eighteen semi-structured interviews were conducted in total.

The analysis of the responses concerning the patient trajectories indicated that the senior managers had a similar understanding of the concept of patient trajectories and its purpose and were committed to supporting the organization in their implementation. In addition, there was a recognition that managing by trajectory would require a change in the role of the senior managers. On the other hand, the necessity to implement immediately, in the first year of the transformation, was not clear. Moreover, the managers displayed an incomprehension of how and why these six trajectories were chosen for the organization. Several challenges were highlighted including the necessity to implement mechanisms for coordination across functional boundaries; the capacity to integrate the concept of managing by trajectory while at the same time integrating the role and responsibilities within the newly formed organization; a perceived lack of resources (training, financial, informational) to implement such an important change; and the incoherence of implementing

management by patient trajectories with the ministerial request for accountability by former installations.

The analysis of the responses to questions concerning SGIP indicated that it was viewed primarily as a performance evaluation model that would facilitate: managing by facts; meeting the expectations of service users and of the Ministry; proactivity versus reactivity; organizational agility; prioritization; and ongoing monitoring of organizational performance. The managers specified the expectation that the system resonate with employees from the various establishments whether they were familiar with a model based on Planetree, Hopital en Santé, Lean or otherwise. They also encouraged integration of its deployment with the various other priorities that were to be cascaded throughout the organization; and expected the Executive Management Team to role model the desired behaviours inherent to the principles underlying the system. The DQÉPÉ Manager (who was also responsible for the Transformation Support Office) was expected to set the tone and provide the necessary support for its adoption.

This analysis was provided to the executive sponsors for the patient trajectories and for SGIP as input to the reflection on the next steps in the development and implementation of these organizational priorities.

1.4.3. The Search for Coherence (October - December 2015)

Efforts by the MHSS

Efforts of integration during this period are seen not only within the organization but also within the Health Ministry. As mentioned previously, the Ministry had indicated their intention to implement Obeya, and had communicated their expectation that all the Integrated Health Networks of the province would do the same. In October, a standard guide for evaluating and managing performance with an Obeya was developed, and training and support for its application was offered by professors of the research centres at the HEC and the UQTR (Pole Santé and IRISS) to

all of the Integrated Health Networks. The standard was shared with the Lean experts of 19 establishments participating in Lean Phase 2 in November, and led to modifications to the functioning of the Obeya at the CIUSSS de l'Estrie— CHUS.

The Ministry also published in mid-November the 2015–2020 Strategic Plan organized around three orientations, responding to three strategic challenges, and including twenty-two specific objectives and performance targets. These challenges, and the specific objectives issued by the Ministry would influence the strategic plan for the CIUSSS de l'Estrie—CHUS, which would be issued in February 2016.

Forming an Organizational Identity at the CIUSSS de l'Estrie— CHUS

This period was characterized by efforts to integrate the various initiatives at not only the strategic level, but also the tactical and operational levels of the organization. Also, evident in this period was the intention of the organization to embody the values and vision of the organization in everyday actions. Members of the Board of Directors were appointed in October, and the first resolution was the elaboration of a declaration of engagement to promote the vision and values established by the CIUSSS de l'Estrie—CHUS in April. Following this, the organization formalized their desire for integration of the values and vision by organizational members with the addition of a new priority; that of creating an identity for the newly formed organization. As one executive manager stated, when questioned on the reason behind this priority, "l'identité ne peut reposer que sur des documents et des paroles[50]."

In October, a multidisciplinary team met to discuss organizational identity. The team perceived organizational identity as the key factor to providing some coherence to organizational actions and decisions. The objective of consciously working on the formation of identity was to ensure that actions were consistent with the vision and values and helped achieve organizational goals.

[50] Loose translation: "The organizational identity cannot be based on documents and words alone."

It was becoming increasingly evident that there was considerable overlap between several of the priorities addressed by the transformational A3s; in particular, identity, SGIP, mobilization of employees, patient trajectories and implementation of the various instances of operational governance structure of the organization. The process of coordination of these A3s between the coordination committee of the Transformation Support Office, the Transformation Support Office itself, and the Executive Management Team was unclear, despite the elaboration of the detailed process depicted in figures 23 and 24. Coherence between these initiatives appeared to be maintained by the interim director of the Transformation Support Office, and not by the process that had been implemented.[51] Concern was expressed on how this coherence would be maintained once the interim was finished. Hence, the organization began to work on organizational identity as a means to provide coherence.

The researcher was asked to participate in this committee and, at the request of the organization, conducted a short literature review on organizational identity. The key elements found in the scientific literature on organizational identity, and more specifically concerning the process of formation of identity were presented to the committee in November. The following is a brief overview of the information provided to the team.

Organizational identity is defined in many of the writings as the features of the organization that are central, distinctive and enduring (Albert and Whetten, 1985). It represents the core values, or the soul, of the organization (Canato and Ravasi, 2015). It is dynamic, anchored in social interaction, negotiated and shared (Gioia *et al.*, 2013; Hatch and Schultz, 2002). Identity reflects the organizational culture, and its external representation is the organizational image (Hatch and Schultz, 2002). The creation of identity is a critical aspect of the formation of an organization as a viable entity (Gioia *et al.*, 2013). It is a complex process that is influenced by both internal and external

[51] Source – complementary documentation to the strategic A3 concerning key learnings

factors. In a newly formed organization, identity claims are made, and the intentions are expressed in the vision for the organization. Organizational members then compare the espoused identity with what they experience within the organization, and the interpretations that they make of organizational symbols. In this way, the espoused identity may be reinforced by the meanings generated in interaction, or refuted, leading to changes in identity. This means that it is not enough for leaders to 'give sense' to members about who they are as an organization. Rather, members need to "make sense of the identity on their own to a certain extent if they are to "buy-in" to the new organization." (Gioia *et al.*, 2013, p. 164).

Noting that the committee had begun work on the creation of the organizational identity as a means to ensure that actions were aligned with organizational objectives and reflected the vision and values of the organization, the researcher also presented an illustration integrating the notion of identity ('who we are,' expressed in the vision and values), and the notion of strategy deployment (aligning actions at all levels of the organization with the strategic orientations of the firm or 'how we do things around here'). The intention of which was to illustrate that the organizational identity was being formed by the way in which the organization was implementing various aspects of their management system currently and could not be separated from discussions concerning SGIP.

The action plan presented by the A3 owner, at the same meeting in November, however, concentrated on a deployment of the vision and values as the primary means for creating an organizational identity. Suggested activities were centred around a clear definition of the vision, values, and management philosophy, a detailed communication plan to all stakeholder groups and integration of the expressed identity in the activities identified to mobilize and engage the workforce.

In December, the A3 on organizational identity was presented to the coordination committee of the Transformation Support Office as per the defined

process for the coordination of the transformational priorities. Several suggestions were made, and were incorporated prior to its official presentation to the Executive Management Team, which did not occur until April of 2016[52]. In the meantime, as will be described in the narrative shortly, organizational identity was integrated into the work on development of SGIP, and in the suggested deployment plan of the integrated management system.

Development of SGIP

While a member of the A3 committee on identity had suggested that each organizational priority should be linked to one of the elements of the organizational vision ("Ensemble, innovons, pour la vie"), the A3 team developing the integrated management system proposed to tie the priorities to an analysis of performance for each of the dimensions of the performance evaluation model using a strategy deployment process. Both teams were struggling separately to find a way to integrate, at a strategic level of the organization, the organizational priorities, and ensure that decisions and actions were coherent with the vision and management philosophy.

Over the period of October to December 2015, efforts concerning the development of SGIP continued. At the tactical level, the conceptual work on the management system to date was informally presented to several senior managers for validation. The meetings provided insight into how the senior managers viewed the level of coherence within the organization at that time, and into the management practices in various sectors. The utility of the A3s was questioned during these meetings. It was noted that they were used as an administrative tool rather than a facilitator to understanding and resolving critical issues in the organization. In addition, it was perceived that most of the initiatives and activities were started without a clear

[52] As per the process of review for the organizational priorities, the Executive Management Team met every two weeks, and alternated between reviewing operational and transformational priorities. As one can imagine, the agendas for these meetings were extremely lengthy, and with the transformational priorities being discussed only on a monthly basis, it took some time for the A3 on organizational identity to be reviewed.

understanding of neither why nor how they fit together. As the philosophy behind the management system was being presented at another meeting, it was questioned whether the desired participative style of management was possible given the 'push' management style that was currently apparent (rapid decision-making at high levels in the organization with little involvement of those closest to the issues, and little explanation of the decisions made). In another area that the SGIP was presented for validation, it was clear that a performance evaluation model was already central to their management practices. Visual management was evident, and a focus on the departmental priorities was clear. The link, however, to the overall organizational priorities was absent.

In addition to conducting validation meetings, the core team responsible for the development of SGIP increased their efforts on integrating various priorities. Meetings were held with organizational members involved in the development of: organizational identity; the organizational approach to patient experience; cross-functional management and facilitation of patient trajectories; and, Obeya and associated performance management. These discussions lead to the establishment of a tactical departmental committee to coordinate several of the initiatives (trajectories, SGIP and visual management) under the responsibility of the DAEPO.

Two key challenges for the development and implementation of SGIP were identified by the core team at this stage; the positioning of the management system at the strategic level of the organization and the temporary status of the process specialists coordinating various elements of the management system. Both issues were highlighted in the key learnings from SPCHUS, but to date had not been addressed within the CIUSSS de l'Estrie — CHUS.

Filling the Void

Against the backdrop of the search for coherence, much of the activity at the CIUSSS de l'Estrie—CHUS in the fall of 2015 was centred around staffing the clinical

organization (replacement of 300 intermediate managers) to take effect on February 15, 2016 and preparing the staff for their new roles. The senior managers continued their reflections on the co-management model for the CIUSSS that would best facilitate the success of management by patient trajectories. The administrative functions prepared and presented their Service Offers for approval by the Executive Management Team. The challenge for the administrative functions in this exercise was to provide support to the clinical organization in the management of the patient trajectories while meeting the financial optimization targets. In most cases, the targets were to be met with headcount reductions through attrition.

During the period of preparation for the clinical reorganization, a certain level of distress was noted in the organization. Issues of concern included[53]: unknown budget allocations, unclear identification of personnel in each service, loss of knowledge during the transition, lack of coordination for the physical relocation of personnel, managing daily operations during the transition, speed with which integration was expected, challenges in communication both horizontally and vertically, and managing a team over a large territory.

Feedback from the engagement survey conducted in the fall of 2015 and presented at the first face-to-face managerial forum (with the approximately 500 senior and intermediate managers) in December, also highlighted several concerns. The results indicated a mobilization level of managers of 92%[54], based on a response rate of 69%. Two elements were highlighted that limited mobilization: lack of involvement, information and orientation; and the context of budget restriction. The number one preoccupation of managers identified in the survey was the impact of the reorganization on the personnel and their teams, as well as on the service user and their families. It

[53] Source: Internal documents of the DRHCAJ documenting feedback from managers collected during workshops held in December 2015 and January 2016, intended to facilitate their transition to new roles following the reorganization.

[54] This is based on responses to the question: In general, I am mobilized to contribute to the creation of the CIUSSS de l'Estrie – CHUS (Disagree, Indifferent, Agree, Totally Agree)

was also highlighted that there was evidence of fatigue among the managers, particularly the administrative managers (appointed to their new position over the summer and early fall). Managers indicated that, to fill the role of leader in the organization, they needed more opportunities to participate in the planning of changes, time to develop a relationship with their hierarchal superior, and more information concerning the short-term objectives (to understand the priorities for the next 100 days). Executive management, responsible for communicating the results, indicated that the next steps would involve communication of the results to the functional directors, who would have the responsibility of analyzing the information with their teams, and implementing actions to address the concerns and the needs expressed in the survey results. There was no mention of the organizational response to the concerns raised.

As the reader will recall, the CIUSSS de l'Estrie—CHUS, had instigated a process for reviewing operational and transformational priorities in September. The clinical reorganization was one of the transformational priorities identified to be reviewed on a monthly basis in the Obeya. According to the process, the transformational priorities were to be reviewed by the coordination committee of the Transformation Support Office prior to being presented in the Obeya. The intention of the committee, composed of members representing various functions and departments, was to coordinate the actions identified on the transformational A3s in consideration of organizational capacity. The committee members, however, expressed frustration and confusion concerning their role. The committee members agreed that improvements were required, and discussion of suggestions for improvements was scheduled for the next committee meeting. This meeting, however, was never held; the committee ceased to exist.

Given the concerns clearly expressed by managers and the dysfunction of the coordination committee of the Support Transformation Office, the DGA's requested support from members of the DRHCAJ and DQÉPÉ to coordinate and sequence the

various activities that would require the participation of the clinical managers. The formal structure of the organization, and the processes and procedures implemented to manage the transformational activities was, unfortunately, not adequately addressing the needs of the managers.

To fill this void, an informal group was formed composed of members from various departments and functions, including finance, human resources, quality and performance, technical services, and information technology. The group took on the role of coordinating the critical activities necessary to address the immediate concerns raised by the managers. Critical activities of the various organizational priorities were managed through a project management governance structure, which included a steering, a tactical and an operational team to ensure the actualization of the necessary actions for implementation. The informal group represented the meta-steering team, responsible for coordinating the overall implementation in a manner that facilitated coherence and provided a pace of implementation acceptable for the clinical managers, considering the implementation date of the new organization on Feb 15th. This informal group met weekly throughout the month of December, with the approval and support of the DGAs, and of the PDG.

1.4.4. The 'Discipline of Getting Things Done'[55] (January - March 2016)

The theme characterizes well this period within the CIUSSS de l'Estrie — CHUS. The emphasis was on improving communication, determining priorities, and aligning the organization towards common goals and culminates with the completion of a Hoshin Kanri[56] exercise for 2016–2017 in June, and preparation for deployment of SGIP in four pilots in July.

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[55] Throughout the year following the implementation of the reform, the Ministry organized several sessions for the PDGs and PDGAs to communicate expectations, and to provide training and support. The workshop during this period focused on strategy execution, with a presentation of the principles of execution from the Bossidy and Charan book *Execution: The Discipline of Getting Things Done*

[56] Hoshin Kanri is a Japanese term that means policy deployment or strategy deployment. Hoshin literally means direction, and kanri translates as means management. Hoshin Kanri therefore consists of two steps: 1) determining the strategic priorities (true north; key objectives) and 2) determining the

Managerial Fatigue

With the clinical reorganization taking effect in mid-February, and the numerous priorities in the organization, higher levels of fatigue were noted among managers. The preoccupation of senior managers with the level of fatigue was voiced at senior management forums held during this period, and echoed in the publication of the survey results by the Association of Health and Social Services Managers (AGESSS).

At the Senior Management Forum[57] in January, Executive Management reiterated its expectation that the engagement survey results be reviewed within the functions, and action plans created to address the issues identified. One senior director reacted to this, indicating that over 50% of those surveyed felt unusually fatigued, which included many of the senior managers present at the forum. He questioned how the organization expected to address the issue. Executive management responded and acknowledged that it was indeed a collective responsibility. One example provided of the actions the organization was taking was responding to late night or weekend emails from employees by suggesting the sender get some rest. No other indication of the organizational response was provided.

The results of the survey conducted by the AGESSS, discussed at the senior management forum in April, echoed the results of the internal survey. According to the AGESSS results, 77% of the participating managers (2534 of 6700 active members of the AGESSS) estimated that working conditions had deteriorated in the last year, and 60% indicated that they had not yet received a clear definition of their role and responsibilities from their employer. From the over 145 pages of comments provided by the participants, the AGESSS noted a marked lack of motivation and high level of

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specific actions required to meet the objectives. It is what "Connects the vision values and philosophies to the daily activity on the floor" (Liker and Hoseus, 2008, p. 429)

[57] The senior management forum includes Executive Managers, Directors, Assistant Directors and Assistants to the Directors (there are approximately 52 senior managers). The management forum includes all senior managers and all intermediate managers totaling approximately 500 managers.

fatigue.[58] The PDG indicated that while the level of fatigue was comparable to the average at the CIUSSS de l'Estrie—CHUS, the organization was better than average in communicating and managing change, based on the survey results. The executive managers indicated their concern, and this time referenced more concrete actions that would be taken. Efforts to facilitate proximity management, to remove irritating factors, and to provide clear priorities were mentioned.

Initial Attempt at Prioritization

Efforts to provide concise and clear priorities began in early January 2016 with the communication of seven critical priorities for the organization for the following 6 months. These included: continued coaching of managers and development of the medical co-management model; introduction of proximity management and relocation of managers; development of an integrated performance management system; animation of patient trajectories; preparation for the Accreditation Canada audit; allocation and balancing of the budget by department; and deployment of employees according to the clinical reorganization. The priorities were based on the work by the informal group to facilitate the implementation of various initiatives prior to the clinical reorganization. On February 15th, the new clinical organization, based on managing by patient trajectories, was formally implemented.

Formalization

Several concerns related to organizational communication, and the role and responsibilities of the various levels of the hierarchy were addressed by changes in the organizational governance structure early in the year. An Executive Committee was created consisting of the PDG, PDGA and the two DGAs. The previously named Executive Management Team became the Senior Management team (the membership remained the same and continued to include the same members [the four executive directors, and the directors of the DRFL, DRHCAJ, DQÉPÉ, and DAR]), and an inter-

[58] Reported in Le Soleil, April 19th, 2017 and Le Quotidien, April 20th, 2016, accessed electronically on March 16, 2017.

directional coordination committee (CCID), composed of the director for each of the functional units, was introduced. Once the CCID was functional, the Senior Management Team was discontinued. This change was introduced to provide the four executive managers a forum in which they could discuss the major orientations of the organization, and improve the efficacy of their teamwork and collaboration.

The informal group created at the end of 2015 to coordinate the essential priorities was maintained; its presence was acknowledged by members of the Executive Management Committee, but had not been given a formal role in the modified operational governance structure. To address this, the informal group proposed early in the year that the process be formalized. Following the presentation of the proposal at an Executive Management Committee, the informal group was informed that they were to cease their activities, until the executive committee determined the appropriate governance structure for coordinating and implementing organizational priorities. The reasoning behind this decision was not provided, and as a result caused some confusion in the organization. It was evident to several organizational members that the formal structure to manage the transformation was not fulfilling its role, and the informal group, with the tacit approval of several executive directors, allowed the role to be filled without directly dealing with the issue of the formal structure. When the activities were ceased, and the members of the informal group no longer felt legitimate in their role, all coordination and integration activities stopped. It was assumed by executive management that these activities would be picked up by instances in the formal structure, however, this was not clearly communicated[59].

At a meeting between the PDG, PDGA, the director of the DQÉPÉ and members of the DAEPO in mid-February, it was announced that an official project

[59] The researcher asked, during the final interviews, about the creation and cessation of the activities of the informal group. Several participants indicated that the reason for the cessation was that it became far too evident that the formal structure was not fulfilling its role. The decision was thought by some to be a question of 'saving face'. Others indicated that it was a question of unclear roles and responsibilities. The reorganization of the management committees and the governance structure for SGIP was thought to have been the replacement for the informal group.

structure for SGIP would be implemented. The steering committee would be the Senior Management Team and would also include the assistant director, the manager and professionals of the DAEPO. The SGIP tactical committee was encouraged to continue efforts to integrate the activities under the responsibility of other departments in their development work. Integration continued and membership evolved over the following months, however, there was a lack of clarity on the role of this committee. Was the creation of the governance structure for SGIP meant to replace the informal group that had ceased its activities? No decision had been communicated by the Executive Management Committee concerning the formalization of the group. One member of the tactical committee commented at the time, "laisser les gens sans direction est inhumain[60]."

Conceptualization of SGIP Begins at the Strategic Level

At the Senior Management Forum in January, SGIP was presented for the first time to all senior managers of the organization, despite the fact that no discussions had been held between the group that had developed the action plan, the director of the DQÉPÉ (the A3 owner) and the PDGA (the executive sponsor for SGIP). The presentation for the forum was prepared by the Assistant Manager of the DAEPO, with the collaboration of the SME for SGIP. At the forum, the PDGA introduced and explained the history of the performance evaluation model, and the director of the DQÉPÉ presented the details of the model, its relationship to an integrated management system, and its role in facilitating management of multiple priorities, decision-making, and working in proximity with employees. The reaction of the senior managers, however, reflects the perception that SGIP was an additional requirement that they were unable to integrate given the period of intense change. The comments also indicate the difficulty in understanding exactly what SGIP was, and a desire to see how the theory translates into action within the organization.

[60] Loose translation: "Leaving people without direction is inhumane".

Also in January, the organization prepared a request for additional financing for the continued deployment of an integrated management system (the financing received for Lean Phase II would end in March 2016). The document was based on a vision originally documented by the SME for SGIP. Several senior and executive directors reviewed the document and provided input for modifications, however, the suggested modifications were never discussed as a group. The final document, described by some as a 'scrapbook' of ideas, reflected the variety of different perspectives of senior managers of the management philosophy and the integrated management system.

While the performance evaluation model was introduced and its relationship to an integrated management system was discussed at the Senior Management Forum in January, and members of Senior Management discussed with the MSSS their request for additional financing, the team responsible for SGIP met for the first time with the PDG and PDGA and the director of the DQÉPÉ in mid-February (the meeting at which the governance structure for SGIP was announced). Much of the time was spent discussing the recent meeting at the Ministry. While no commitment in terms of additional financing was made, the PDG did indicate that the professional resources supporting the development and deployment of the various elements of the management system would be offered permanent positions. The remainder of the meeting was spent on presenting and discussing the vision of SGIP.

As the presentation of the performance model and its relationship to an integrated management system at the forum in January led to considerable confusion, the distinction between the two was addressed by members of the DAEPO at this meeting in mid-February. It was explained that the performance evaluation model was an excellent tool for deploying strategic objectives, and monitoring performance on key indicators, nonetheless, it was only one element of an integrated management system.

The vision of an integrated management system, as documented in the request for financing to the Ministry, was summarized as follows:

> Transformer la culture de gestion afin de voir naître une organisation apprenante capable d'améliorer en continu la performance des trajectoires des usagers. Dans cette organisation, tous les acteurs sont mobilisés et contribuent de leur plein potentiel à l'amélioration de l'accessibilité, de la qualité et de la sécurité des soins et services tout en réduisant les coûts d'opération via une meilleure utilisation des ressources.
>
> Le système de gestion vise à baliser les interactions humaines afin que tous les acteurs sortent des silos et agissent au quotidien sur ce qui est vraiment important dans la mission de l'organisation. Le mode d'interaction souhaité est défini par l'identité et par les valeurs organisationnelles, et est actualisé dans l'action grâce au coaching. Les cogestionnaires deviennent davantage des « coachs » que des experts et priorisent le développement de l'intelligence collective de leur équipe afin qu'elle résolve des problèmes de plus en plus complexes.
>
> L'avancement de la transformation est contrôlé par des mesures périodiques de maturité de gestion selon les 4 dimensions inscrites ici-bas.
>
> LES DIMENSIONS DU SYSTÈME
> La raison d'être : travailler avec et pour l'usager et ses proches dans les trajectoires de soins et services.
>
> La mécanique : déployer les objectifs stratégiques dans toute l'organisation.
>
> Le savoir-être : développer la cogestion dans une culture de leadership transformationnel.
>
> Le savoir-faire : être outillé à l'amélioration continue des processus[xxvi].

At the end of March, for the very first time, the Senior Management Team discussed as a group the integrated performance management system, and the organizational management philosophy. The basis for the discussion was the vision document that was prepared for the Ministry to support the request for financing. It was clear from this meeting that opportunities to discuss and share individual understandings of various organizational elements at this level were rare. Similar to SGIP, the conception of managing by patient trajectories, and the integration of the mission of University Hospital into an integrated health network, both the subject of

discussion during the meeting, was not understood nor shared by the senior managers. They were, in fact, subject of some debate.

It was at this meeting that it was announced that the Senior Management Team would transition into the Steering Team for SGIP and would be responsible for piloting organizational performance in the Strategic Obeya.

The Steering Team completed their group reflection on the managerial vision for 2020 over the months of April and May. Early in April, the team participated in a full-day workshop on the ministerial guidelines for the Strategic Obeya. It was emphasized in the training that there would be no value in a strategic level Obeya if performance management was not deployed all the way down the hierarchal structure to organizational members that are closest to service users. While the Obeya may be seen as a tool, it was emphasized that its function was to facilitate, align and coach, instead of controlling, for performance improvement. It was not simply a tool for facilitating coherence of action and performance improvement, but was thought to be a system whereby visual management and employee involvement are key. Facilitation is carried out according to the principles of proximity management and shared leadership. The documents posted in the Obeya are intended to represent the current performance, strategic challenges, organizational priorities, and key projects. Animation of the Obeya should be focused on supporting daily operations (and not on simply reporting results), leading senior managers to reflect on their role in supporting employees in removing roadblocks to improved performance. Based on this understanding of the Obeya, the Steering Committee decided to eliminate the concept of ambidextrous management, positioning instead the transformational priorities at the service of daily operations.

While experimentation began with the strategic Obeya, the steering team determined the specific areas where SGIP would be deployed. Two administrative functions were chosen (the DAR and the DQÉPÉ), along with two clinical functions

(DSP, and DI-TSA-DP). The two directors of the clinical functions, not members of the Steering Committee at that time, were invited to join the committee in April. The governance structure adopted and the roles and responsibilities of each of the committees are presented in Figure 25 and Table 10.

Figure 25
Governance Structure for SGIP

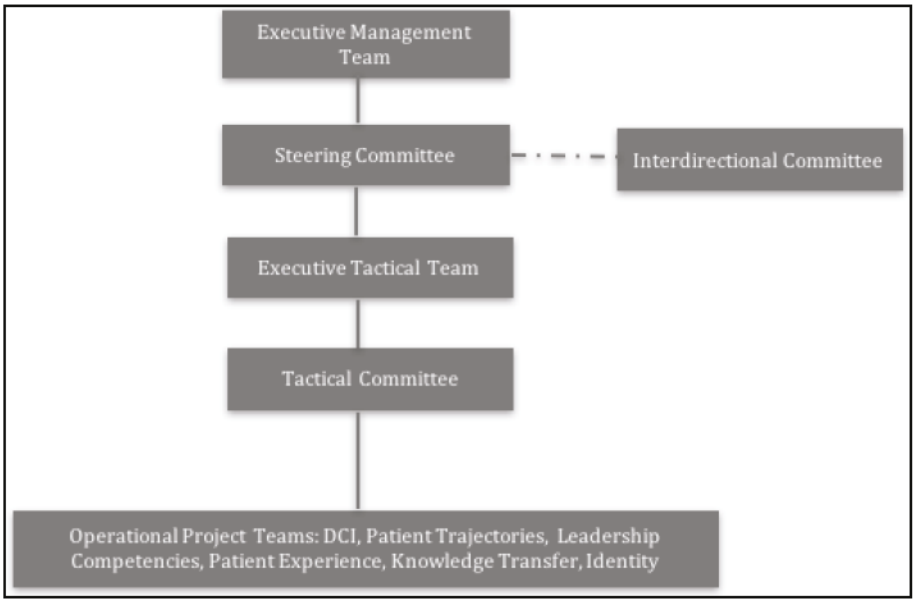


Table 10: Roles and Responsibilities SGIP

Committee	Role	Members
Executive Management Committee Frequency: every week for 2 hours*	To support the vision of the integrated performance management system and the coordination of changes resulting from its deployment *SGIP was included in the agenda of the weekly meeting every two weeks, at the meeting preceding the steering committee meeting.	The four executive managers
Steering Committee Frequency: 120 mins every two weeks (45 mins for piloting performance, and 175 mins for SGIP)	Strategic management of SGIP. Responsibilities include: • Approving the specific project orientations • Discuss and address any obstacles to the deployment of SGIP • Monitor performance indicators and take actions necessary to support employees in meeting strategic objectives.	The PDG presides this committee. Members include: the four executive managers, the directors of the DRHCAJ, DFRL, DQÉPÉ, DAR, the directors of the pilots DSP and DI-TSA-DP, members of the DAEPO.
Executive Tactical Team Frequency: Every two weeks, following the steering committee	Coordinate the activities of the steering and tactical committees. Responsibilities include: • Preparing the steering committee meetings • Escalating issues raised at the tactical level to the strategic level • Cascading decisions and orientations from the strategic to the tactical level • Ensure alignment and coherence in communications and actions.	The director of the DQÉPÉ presides this committee. Members include: the DAEPO assistant manager and the program manager (manager of the organizational performance service).
Tactical Committee Frequency: 120 minutes every week	Recommends to the Steering Committee the actions required for the implementation of SGIP, and provide guidance to the Program Manager throughout the project. Responsibilities include: •Facilitate integration and coherence between the various dimensions of SGIP •Discuss and coordinate the activities of each of the operational project teams. •Find solutions to issues raised from the operational level, where possible, and escalate if support is required at the strategic level •Ensure that activities at the operational level are aligned with the vision and strategy determined at the strategic level.	The Program Manager presides this committee. Members include: the Subject Matter Expert (SME) for SGIP, and the owners of the operational projects (model of co-management, patient trajectories, identity, patient experience, communication, DCI, and performance management).
Operational Project Teams Frequency: determined by each project team.	To coordinate the appropriate resources to implement each of the project lots per the sequence determined by the tactical committee. Responsibilities include: •Develop and implement the project plan •Identify issues and where necessary escalate to the tactical committee	The project owner presides their operational team and includes the participants identified by the owner.

1.4.5. Deployment of SGIP (April - December 2016)

Difficulties with Open and Transparent Communication

With the reorganization of the organizational structure in January (creation of the Inter-Direction Committee [CCID], and the Executive Management Committee [EMC]) and the inactivity of the Transformation Support Office, the A3s were presented directly to, and reviewed by, the EMC. The owners of the A3s were invited to present to the executive directors and answer any questions that they may have. The EMC, following the departure of the owner from the meeting, then discussed the actions that should be taken. The decisions were communicated back to the owner at some point following the meeting. This mode of operation, dialogue and decision-making by the EMC, without the involvement of those directly responsible, was noted on various different occasions in the organization. As one can imagine, with the sheer number of priorities in the organization, the EMC was unable to discuss and make decisions on all of the information that was presented to them. Several issues were left unaddressed, and the owners left without clear direction.

One such issue was the organizational identity. During the month of April, the A3 concerning this transformational priority was presented for the first time to the Executive Management Committee. Note that the A3 had previously been reviewed by the now defunct coordination committee of the TSO back in December of 2015. The executive managers found the suggested actions too theoretical and did not address how the identity would emerge from action. The committee indicated that they would, in a closed session, discuss and define the attitudes and behaviours that reflect the expressed identity[61].

[61] To the knowledge of the researcher, no feedback was ever provided by the EMC in terms of attitudes and behaviors. Instead, as will be seen shortly in the narrative, the tactical committee for SGIP ensured that the development of key behaviors aligned with desired management practices were aligned with the organizational identity.

A second issue that was left unaddressed concerned organizational communications. There was some confusion concerning the role of the Tactical Committee for SGIP with respect to organizational communication (which will be discussed in more detail in a moment), and at the same time, the feedback from managers indicated that there were some deficiencies in the current communication methods. A proposed process for preparing and communicating the key messages at the various organizational meetings and forums was presented. No feedback on this proposal was provided by the EMC.

In addition to their direct role in reviewing and determining appropriate actions concerning the organizational priorities, many issues raised in the biweekly facilitation of the Obeya were tabled, and also transferred to the EMC discussion behind closed doors. Feedback, if provided was given at a subsequent Obeya meeting.

Attempts at Improving Clarity and Focus[62]

The focus of the strategic and tactical teams during the month of May was focused on the "kickoff" for SGIP during the May Senior Management Forum.[63] It is of interest to note how the key messages for the kick-off were planned, as it illustrates well some of the issues with communication in the organization. The intention of the Forum was provided by one DGA and communicated to the PDGA. The information was then filtered down through the director of DQÉPÉ to the assistant director, who then, with the tactical team proposed an agenda for the meeting. Refinements were made through repeated emails and phone conversations between the EMC, the PDGA

[62] One influential element for the organization was the keynote presentation by Karen Martin at the annual lean conference in May in Chicoutimi. Ms. Martin is the author of the book "*The OUTSTANDING Organization; Generate Business Results by Eliminating Chaos and Building the Foundation of Everyday Excellence*". The key message of the book, and the keynote speech, consisted of explaining how to create the conditions necessary to achieve excellent organizational results: Respect for people, Clarity, Focus, Discipline and Engagement. The EMC found these conditions compelling and began to associate them with the objective of the integrated management system and its deployment.

[63] SGIP had been introduced in January, prior to any discussions at the most senior levels of the organizations. As understanding of SGIP by Steering Committee had evolved, it was judged necessary to re-launch SGIP in the organization, and the communication forum in May 2016 would be the official "kick-off".

and the tactical committee in order to ensure that the agenda was in line with the intention of the DGA. Just two days prior to the forum, the detailed agenda was confirmed. A lot of time and effort was spent on preparing the presentations, with little group discussion on the key messages to be delivered.

On May 26th, SGIP was formally launched (even though the performance evaluation model was introduced in January). Changes were noted in the style of presentation of the Executive Directors during the forum, with evolution to more interaction with senior managers during the meeting. The message, however, concerning the goal of SGIP did not appear to have been understood by the senior managers, based on feedback following the forum.

In June, the organization completed their first Hoshin Kanri. It should be noted that in April the strategic plan for 2016–2017 was presented to, and accepted by, the Board of directors. This plan was developed by a member of the DAEPO for the PDGA in February. This plan consisted of the integration of the elements of the Strategic Plan issued by the Ministry in November 2015, and the organizational priorities that had been translated into organizational A3's. The Hoshin Kanri completed in June, on the other hand, represented a collaborative effort of the SGIP Steering Team in determining organizational priorities. The two strategic plans would be maintained in the organization until the strategic planning cycle for 2017–2018.

Beginning in March and continuing through to May 2016, the researcher conducted 11 semi-structured interviews with the members of the Steering Team (4 Executive Directors, 6 Directors and 1 Senior Manager). The objective of the interviews was to get a feel for the general understanding of what SGIP meant to various organizational members, and to identify perceived challenges facing its implementation. A summary of the analysis was presented to the Steering Committee for SGIP in June, prior to the Hoshin Kanri workshop, along with the key learnings

from SPCHUS was presented with the objective of providing material for reflection in determining the deployment activities for the remainder of the year.

The analysis highlighted the extent of the challenges facing the organization following the implementation of the reform. Structuring the organization around patient trajectories was perceived as being extremely complex, and generated both confusion and ambiguity within the organization. The sheer size of the CIUSSS de l'Estrie—CHUS highlighted several weaknesses in the mechanisms for communication and coordination. The rapidity with which changes and decisions were being made left little time for reflection concerning the impact of the decisions, and little time to reflect on management practices. Many managers, therefore, relied on their natural management reflexes, which was described by interview participants as autocratic and top-down. This style of management was at odds with the stated organizational values and management principles, leading to a lack of coherence between the espoused values and the actions of senior leaders. Examples provided by participants included: the requirement to have a senior manager approve the purchase of a $100 item when accountability was one of the management principles; and sending 250-page documents at the end of the day to be reviewed for an early morning meeting, or requesting a status report at 4 pm on a Friday for early Monday morning, when one of the core values was humanism (and the engagement survey indicated a high level of fatigue among managers). It was also noted that the CIUSSS de l'Estrie—CHUS demonstrated a strong desire to be 'top of the class' in all areas, leading to a work pace that was perceived as being unsustainable and lacking in focus. And finally, the constraints of the imposed reform itself were seen as a major challenge to focusing on the needs of service users.

This portrait of the organization was perceived to be a just representation of the organization by the interview participants following the presentation of the results. The discussions concerning the learnings from SPCHUS were brief, and centred more on

emphasizing the accomplishments rather than the learnings that could be applied to the deployment of SGIP.

The second face-to-face organizational Management Forum was held in June, prior to the finalization of the Hoshin Kanri. This was the first forum of managers since the reorganization, both administrative and clinical, had been completed. Executive Management emphasized their appreciation for the efforts made by all managers, and those still to come, to continue to provide quality care and services. The Executive Committee mentioned the work being done to eliminate many of the irritants caused by the transformation and to ensure an adequate work environment for managers. The Hoshin Kanri was provided as an example of efforts to provide focus through the determination of critical priorities for the organization. The PDG mentioned the importance of determining realistic, yet ambitious, objectives for the organization.

The results of the second engagement survey were communicated during this forum. The level of mobilization, measured in the same way as the first survey, dropped from 91% to 81%. A high level of fatigue among managers was again noted in the results, along with a strong desire to have a clear indication of the organizational priorities, selected as a function of their impact on critical performance indicators and the organization's capacity to execute.

The operational strategic plan for 2016–2017 resulting from the Hoshin Kanri workshops held in June consisted of 33 objectives, 11 of which were considered critical for the organization and would be piloted in the strategic Obeya. One of the 11 critical organizational priorities, in addition to those defined and cascaded by the Ministry, was the deployment of SGIP. The steering team approved the deployment plan prepared by the tactical team at the end of June. To manage the development of the elements of an integrated management system, SGIP was divided into specific project "lots" and the owners for each of the lots were slowly integrated into the tactical team meetings over the following months. Efforts of the team were on creating a common understanding

of SGIP, and integrating the various elements that were being developed independently within the organization.

Integration of initiatives under the responsibility of the DRHCAJ and the DQÉPÉ during these months was significant for the organization. The two groups developed, for the first time, a mutual understanding of SGIP, its role in day-to-day management, and in organizational development. The development and training plan for managers was then created in an integrated fashion, aligned with the management philosophy that had been endorsed by senior managers in the organization.

Also during this period, members of the DRHCAJ and the DAEPO conjointly worked on identifying the key behaviours of the desired management practices, which would be used as the blueprint for the development of managers over the following two years. The leadership competencies reflected the management philosophy expressed within the vision of SGIP, and were inspired by the LEADs framework, and a person-centred approach to healthcare. An action learning approach was suggested and approved, whereby the facilitators would through action learning, begin experimenting the development of the identified competencies themselves (with the support of an experienced coach), while coaching managers within the pilots. The managers would learn in action specific behaviours that reinforced the desired management practices and would then be able to coach the members of their teams. The paradigm changes on which the specific behaviours were identified are summarized below in Table 11.

Table 11
Desired Changes in Management 'Paradigms' for SGIP

Current	Desired
Service user viewed as a passive actor	Service user viewed as a partner
Service user informed	Service user listened to
Manager as expert	Manager as coach and role model
Large-scale projects	Daily continuous improvement
Open door policy for managers	Go to the workplace, where value is created
Multiple priorities	Organizational focus based on clear objectives
Reactive measures	Proactive performance management
Management by functions	Matrix' management

The lack of coaching of the Executive Managers concerning the development of competencies, that would be the basis for the development of all managers within the organization, was identified by the tactical team as a serious issue.

> Qu'ils se fassent accompagner ; c'est probablement un symptôme d'un autre problème. L'autre problème c'est qu'ils n'ont pas le temps de poser un regard sur l'interne de l'organisation puis de piloter un changement de cette ampleur-là s'ils n'ont pas la capacité. Fais que c'est ça ; comment faire pour travailler là-dessus[xxvii]. (Professional)

While coaching on critical behaviours was not deemed a priority of the EMC, one of the Executive Directors requested the development of specific tools for the facilitation of intra-direction meetings and for statutory meetings. These were developed by professionals within the DAEPO, and were introduced into the DGA of Specialized and General Medicine. Some coaching was provided concerning the use of the tools, and appreciation for the new format of the meetings was expressed by participants. These tools would later be transferred the DGA of social and

Rehabilitation Programs, and it was the intention of the organization to introduce across all of the administrative directions as well[64].

From August to December 2016, continued efforts at providing clarity and focus were evident. Strategy deployment of organizational priorities in four pilot directions began in August; the 11 critical strategic priorities were communicated to Directors and Senior Managers at the CCID meeting and the senior management forum, both held in September, and to all managers at a videoconference in October; and the animation of two patient trajectories commenced in December. As one executive manager mentioned, the previous year the organization had been focused on executing the tasks necessary for the integration of the previously independent establishments into the CIUSSS de l'Estrie—CHUS, and now with the development of an integrated management system, attention could be directed to assuming the appropriate roles at all levels of the organization.

The two clinical directions, DSP and DI-TSA-DP were the first to begin deployment in August. The two administrative functions, the DAR and the DQÉPÉ followed in September. The importance of SGIP in ensuring that organizational members were working on the right things at the right level of the organization was a key message of the executive managers when introducing the system. One of the four pilot directions, DI-TSA-DP, was also one of the six patient trajectories identified in the organization. During the deployment, it was mentioned on several occasions that they would be deploying both SGIP and patient trajectories. This discourse became more and more frequent in the organization; the patient trajectories were viewed as separate and independent from SGIP.

While some concern was expressed on how to coordinate with other functions in meeting objectives, the deployment of strategic priorities was viewed positively in

[64] As of the researcher's last meeting with the organization in August 2017, the tools had not yet been introduced in the administrative functions.

both pilots, as evidenced by the comments of members of the management team in one of the pilots.

> J'attends ça, j'ai besoin de s'attacher à quelque chose plus gros que notre direction[xxviii]
>
> Donnez-nous le cadre et laissez la place à la co-construction[xxix]
>
> Le cadre va nous aider à garder un focus, et à renoncer à des choses[xxx]
>
> Avec l'approche proposée, on a l'impression de faire partie d'une grande équipe. Avant on travaillait chacun pour soi, maintenant on est intégré dans un système et on travaille ensemble[xxxi].

Deployment of SGIP in the DAR, on the other hand, was difficult. Questions were raised on why they were identified as a pilot, when the vision of the integration of a University Hospital within the CIUSSS had yet to be established. The role of the research centres in contributing to the strategic organizational priorities of the CIUSSS de l'Estrie—CHUS was unclear, leading to considerable discussion, and to modifications to the deployment scenario within the function.

Translating the Strategic Operational Plan for 2016–2017, detailed in the Hoshin Kanri, to all the pilots presented certain difficulties for the professionals responsible for facilitating the deployment. Many of the objectives were in fact-specific projects, many were not specific or measurable, and it was questioned if the organization had the capacity to address 11 critical and a total of 33 objectives annually. All the same, the facilitators succeed in accompanying each of the pilots in determining the critical actions required to support the organization in addressing the strategic challenges. Throughout the deployment, adjustments were made based on the experimentation, and learnings were documented by the facilitators. While reflection on the learnings of the initial Hoshin Kanri exercise was not discussed at the Steering Committee Meetings, the DAEPO used their learnings in adjusting the process for the 2017–2018 cycle to begin in February of 2017.

Evidence of Confusion

Over the summer and fall, the steering team continued its experimentation with piloting organizational performance. The piloting occurred every two weeks following the standard format of facilitation proposed by the Ministry. Strategic indicators for each of the dimensions of the performance model had still not been finalized, and the difficulty in obtaining data for the desired indicators was noted. Discussions concerning performance were centred on providing information on the advancement of specific projects and on justifying the current situation, not on actual performance levels nor on removing obstacles and addressing issues that were raised at the tactical level in the organization. Facilitation of the strategic Obeya was cancelled on several occasions during this period due to conflict with other organizational priorities.

There was also considerable evidence of misunderstanding concerning the responsibilities of the various committees of the governance structure for SGIP. In August, the communication plan for SGIP, following the kick off in May at the Senior Management Forum, was proposed to the Steering Committee. The sequence of activities and various communication tools were adopted, however, the key messages to be communicated were not provided. It was suggested by the tactical committee members that the responsibility for the development of these messages belonged to the Executive Management Committee. One executive manager responded that a bottom-up philosophy of management implied that the key messages should emerge from lower levels in the organization. This echoed a very similar discussion that had occurred during meetings concerning organizational identity. An executive manager at the meeting commented that the activities to deploy the identity appeared to be mostly "top down" with not enough place for the "bottom up" described by the executive as "aller vers les gens pour faire vivre ça… partir en bas pour qu'ils nous alimentent[65]." These discussions highlight an important discrepancy in understanding of top down and bottom up at the tactical and strategic levels of the organization.

[65] Loose translation: "Reach out to employees to bring it to life…let them create the vision."

1.5. Key Learnings from the Second Action Research Cycle

In October 2016, a summary of the second action research cycle was initiated. A presentation of the events concerning the development and implementation of an integrated management system from April 1, 2015, up until mid-October 2016 was prepared for a group discussion with the tactical committee. In addition, the researcher analyzed and presented the learnings that had been documented by Pole Santé and IRISS concerning Lean Healthcare Phase I and Phase II, with the objective of stimulating reflection concerning their experience in the context of the experience of other organizations adopting a similar management philosophy. The analysis of the discussion and subsequent interviews was the basis for the identification of the key learnings.

Following the presentation by the researcher, the tactical team indicated that the narrative was a just representation of the events concerning SGIP. The comments and feedback on what can be learned from the narrative about the organization, and more specifically about the adoption of an integrated management system, was included as data in the analysis to identify the key learnings. Twenty-one semi-structured individual interviews with the participants of the tactical committee and the steering committee, and with the deployment facilitators were conducted following the group discussion with the tactical committee. The interview guide (included in Appendix D) was divided into two sections. The first section was intended to understand from the participant's perspective the critical events, challenges, successes and learnings from the deployment of an integrated management system. The second section included a variety of questions to understand changes to meanings and interpretations that may or may not have occurred. The analysis of the second section contributed to the cultural analysis, which is presented in Section 3 of this chapter.

As with the first action learning cycle, the focus group discussion and the individual interviews were transcribed, and were analyzed in NVivo. Iterative cycles of analysis and memo writing followed the macro coding leading to the identification

of the critical events and decisions, and of the challenges facing the organization concerning the deployment of a management system. The analysis also provided a qualification of the progress made, and the identification of key learnings. The learnings that emerged from these iterative cycles of analysis, were then compared and contrasted to observations and field journal notes, and to data found in the secondary documentation leading to further refinement.

While the researcher was completing the arduous task of analyzing the abundant data, the tactical team prepared to communicate suggested adjustments to the Steering Team, based on the group discussion in October. Section 1.5.5 provides details on the suggestion, and the response of the Executive Management Committee. The final analysis of learnings from this dissertation was formally presented to the Executive Management Committee (who had become the steering team for SGIP) in April 2017, and to the tactical committee in June 2017. The reaction of the research participants, and their intentions in the continued deployment is presented in Section 4 of this chapter. This represents the formal end of the research project.

1.5.1. Critical Decisions, Actions, Events

The decisions, actions and events that were identified by participants as key to the development and deployment of SGIP within the CIUSSS de l'Estrie—CHUS was supplemented and refined based on observations by the researcher, as done in the first action research cycle, and were used to construct the timeline of activities presented in Figure 7.

1.5.2. Qualification of the Progress Towards the Vision for SGIP; Elements of Pride and of Deception in the Deployment.

The qualification of progress in the deployment is based on the vision, as presented in section 1.4.4 and observable changes in management practices towards the desired behaviours as described in section 1.4.5. Participants also referred to

organizational performance, and the scorecard of implementation in the four pilot directions when discussing their perception of progress.

Readers will notice the qualification of progress is very similar to that documented in the first action research cycle. Pockets of change are evident, progress is non-linear, communication, collaboration and integration are laborious, there is both satisfaction and frustration with the length of the conceptual period, yet there is optimism that sustainable change has and will continue to occur.

The context of the reform, the creation of the CIUSSS de l'Estrie—CHUS and all that it entails influenced greatly the perspectives of the participants. Forming an identity for a complex organization of over 17,000 employees, previously members of 15 independent organizations is no small feat. From the point of view of participants from the CHUS, progress was extremely difficult as it was perceived that they took a giant step backwards since April 1st, 2016, in terms of the organizational understanding of what an integrated performance management system was. For these participants, progress was seen as minimal.

> Minime. Parce qu'on a fait un pas en arrière. Dans le fond on lutte pour revenir. […] De refaire des étapes qui ont déjà été faites, mais on ne va pas nécessairement beaucoup plus loin. Je n'osais pas mettre un pourcentage, mais ce n'est certainement pas plus que 10% dans ma tête. […] on voit bien qu'autour de nous quand on parle de ça des fois, on se fait regarder un peu comme des extraterrestres. J'imagine que pour les gens dans les autres installations, qui géraient la performance d'une autre façon, il doit y avoir un peu le même *feeling* s'ils se parlent entre eux. « Ah tu sais à l'époque on aurait fait ça comme ça, comme ça, comme ça. » Puis c'est pour ça que la culture n'a pas évolué. Je pense qu'on a juste pris un pas en arrière puis probablement que ce qu'on fait va nous amener à être meilleurs ; sinon d'unifier puis d'avoir une standardisation, une harmonisation des pratiques[xxxii]. (Senior Manager)

For other research participants, progress had been modest, seen mostly at the level of discourse and intentions, and not necessarily in the actions.

> On n'est qu'au début. Vraiment on n'est que dans les intentions[xxxiv]. (Senior Manager)

> On a vu, la semaine passée - ça a été une opportunité pour voir les visiteurs[66] ont vu qu'il y a beaucoup de gens qui parlent du système de performance ; de la nécessité de faire de l'amélioration continue. Les mécanismes standards. On le voit. Ça commence à percoler, mais peut-être qu'on n'aurait dû être plus loin que ça, à l'intérieur d'un an et demi ; mais on n'est pas très loin. Donc je pense que ça commence[xxxiv]. (Manager)

While others indicated that change had not occurred, instead the previous management practices had been reproduced in the new organization:

> Non. Je pense qu'on est juste en train de reproduire ce que les dirigeants faisaient dans leur ex-organisation. Je l'ai entendu à différentes reprises. Je ne dis pas ça péjorativement encore une fois, mais on n'est pas juste en train de changer la culture. On est juste en train de reproduire une culture qui existait déjà à certains endroits[xxxv]. (Senior Manager)

The changes that are noted, to the satisfaction of participants, concern the implementation of several of the tools associated with lean management. The animation of a strategic Obeya, the strategic Hoshin Kanri exercise and deployment of the objectives in four pilot directions, and the identification of patient trajectories and animation of these trajectories in two pilots.

> Le fait qu'ils aient vraiment fait un plan annuel sur lequel ils animent leur pilotage. Le fait qu'ils aient cascadé en partie. On va voir pour les directions. Ils ont transmis ce focus-là dans chacune des directions […] Et donc, pour moi, ils parlent plus du contenu que du contenant, que du système. Ce qui me semble approprié. Il faut le vivre et non pas demander aux gens de l'imaginer[xxxvi]. (Professional)
>
> Moi je pense que oui. Ça représente un vrai changement dans le sens où il y a une gestion de priorités. Ce qui ne se faisait pas dans certains ex-établissements-là[xxxvii]. (Director)
>
> On n'avait pas vraiment de cible auparavant dans les plans annuels. Là, on en a moitié-moitié. Donc, éventuellement, l'année qui suit dans les apprentissages, on fera moins d'efforts pour construire le plan annuel ; parce qu'il y a une portion qui va être reconduite. Une bonne portion d'énergie pour améliorer la clarté de la destination

[66] auditors from Accreditation Canada in October 2016

> pour nos gens ; puis eux ils vont attraper la balle au bond et voir quelle contribution ils font[xxxviii]. (Professional)

As one executive manager noted, the turmoil of the reform and restructuration of the new integrated health networks led to a fury of required action, that finally abated leaving room for more reflection and more planning. It was perceived that as the organization matured, the integration of learnings would be more likely to occur:

> Je pense que l'organisation est aspirée dans un paquet d'actions qui doivent être posées. Plus l'organisation prend de la maturité et que le nouveau système prend de la stabilité, plus on réalise qu'il y a des moments de planification, de partage de connaissances qui devront prendre de la place dans nos ordres du jour, puis on arrive à ça[xxxix]. (Executive Manager)

While some members indicated that the key learnings from the first action learning cycle were not integrated in the second action learning cycle, several observations indicated that some learning may have occurred: senior managers were involved in the creation of the overall vision for the organization; the governance structure was partially integrated in the functional hierarchal structure; and executive managers and directors were directly involved in the deployment within the pilots.

Within the pilots the most notable progress had been made in the DSP and DI-TSA-DP. Decision-making was noted as being more participative, collaboration had improved, problem solving had become more methodical, and there was more focus on organizational priorities.

> La prise de décision partagée, un peu plus. Un exercice de transparence, davantage. C'est moins la recherche d'un coupable et plus l'identification des écarts puis l'identification des solutions. C'est un peu moins dans le paraître puis un peu plus dans « on peut tu vraiment se regarder là » ? Même si c'est très difficile encore[xl]. (Director)

> La capacité de certaines directions à initier l'analyse d'une situation pour la recherche des causes ; pas juste à l'intérieur de leur silo, mais interpeller les partenaires. Elle est beaucoup plus grande qu'elle l'était. J'entends moins de « ça ce n'est pas mon problème, c'est le

> tien. » On entend davantage, même verbalement, les gens se reprennent quand ils vont dire « bien là... ça c'est notre difficulté avec tel élément. » Donc, ça, c'est quand même des éléments de culture[xli]. (Director)

> On est plus focusé sur les opérations. Sans faire de l'opérationnel, que ce soit clair. On n'est pas en train de régler de l'opérationnel. C'est comme, on sait qu'on a un enjeu de durée moyenne de séjour à Granby qui est très élevé. Il y a un plan d'action qui a été proposé ; où est-ce qu'on est rendu, qu'est-ce que ça veut dire ; on partage cette information-là puis on trouve des leviers puis on convient des étapes ensemble. On est beaucoup plus dans la gestion stratégique des opérations, moins dans l'aspect politique communicationnel[xlii]. (Director)

Outside of these areas, progress was not evident. Changes in management practices at the executive management level were extremely variable; moving from a theoretical understanding of the system to incorporating the philosophy in daily management of the organization appeared difficult, as evidenced by the following observations:

> C'est sûr qu'au niveau de la direction générale, qui est la première direction pilote parmi les cinq, on ne visualise pas encore certains gestes clés en lien avec, comment dire, poser plus de questions qu'apporter de réponses. Puis l'autre geste clé, qui est partiel quand on regarde le plan annuel, c'est de déterminer la destination. Plus la cible objective plutôt que de dicter des moyens[xliii]. (Professional)

> Une façon d'animer, je pense qu'on arrive à des choses intéressantes avec les cadres supérieurs ; mais animer nos rencontres au niveau de l'ensemble des gestionnaires du CIUSSS de l'Estrie-CHUS, je pense qu'on a quelque chose à faire encore de ce côté-là. On a eu des bons forums. C'est intéressant, mais tu sais, arriver à faire le lien avec notre vision du système de gestion intégrée de la performance puis ces rencontres-là, c'est encore un défi[xliv]. (Director)

> Au niveau de comité[67] oui. Bien maintenant, quand on sort de ce comité-là, non. […] Quand on sort de cette rencontre-là, c'est comme si ça n'existait pas. Mais dans cette rencontre-là, oui. Fais que je me dis « bien ça a du potentiel », mais je pense que les gens ne le voient pas[xlv]. (Director)

[67] Comité de pilotage.

There was most definitely a sense of pride in what has been accomplished despite the turmoil caused by the reform, particularly in the collaboration among the members of the tactical committee. There was an equal dose of disappointment in many aspects of the introduction. The power of daily continuous improvement and an integrated management system is unleashed when it is introduced at all levels of the organization, from executive management to those working closest to the service users. Unfortunately, the management system had not yet progressed all the way down to frontline workers in the organizations, so the benefits were difficult to see.

> Bien il est bipolaire le progrès. Il y a quelques joueurs dans l'organisation qui ont été influencés. Je prends le comité tactique, c'est la même chose que notre ancien groupe de conception. On a répété la même affaire où on expérimente, on essaye d'implanter des affaires puis on fait des apprentissages. Ce groupe-là a beaucoup d'apprentissages de fait. Mais ce n'est pas le plus important. On n'a pas réussi à amener ça au bon niveau encore à l'organisation[xlvi]. (Professional)

Also disappointing was the dysfunction of the relationship between the strategic level and the tactical level committees. The issues and challenges that were identified at the tactical level were not discussed at the strategic level. Obstacles and barriers were not lifted, and advancement in the deployment became difficult.

A lack of courage of conviction, ensuring that actions and decisions were aligned with the vision of the organization and dealing with poor performance, was also identified as a source of disappointment in the implementation of the system:

> Ce qui me déçoit c'est, bien, c'est ça, c'est de le porter dans les actions pas juste dans les discours. C'est aussi d'avoir le courage de ses ambitions. C'est-à-dire que si la direction générale souhaite implanter un système de gestion intégrée de la performance avec des leaders qui sont en leadership transformationnel, ils ne sont pas sans savoir qu'actuellement ils ont un certain nombre de cadres qui ne cadrent pas avec un modèle de leadership transformationnel ; et qui, pour qu'ils arrivent à avoir un style de leadership qui est un leadership transformationnel, deux choix : soit qu'on arrive à la conclusion qu'ils ne pourront pas ou les mettre hors d'état de nuire.

> Ou, il faut un investissement de temps et d'énergie, de coaching au quotidien qui actuellement n'est pas là[xlvii]. (Senior Manager)

And finally, a lack of strategic vision and expertise in introducing an integrated management system was highlighted. The tactical team took on the responsibility of creating a global vision and of aligning communication across the organizational forums. As will be discussed and explained more fully in the following section, this brings with it a lot of confusion, and leads to the risk of misinterpretation and misalignment as the tactical team members did not necessarily have a global view of the organization and its external environment.

> Ce qui me désole c'est qu'on n'ait pas pu trouver le fil conducteur pour le système de gestion intégrée. Le modèle qui est devenu le système... ce qui me désole c'est qu'on n'ait pas pu penser à une stratégie d'introduction progressive qui aurait pu donner un sens. Là on est pris à essayer de démontrer à tous nos gestionnaires qu'on n'ajoute pas une couche puis ça, je trouve ça désolant ; parce qu'on aurait pu y penser davantage et avoir une stratégie gagnante d'introduction dès l'automne, même si on restructurait. Trouver des éléments qui auraient été gagnants puis on a trouvé des éléments à restructurer par rapport aux trajectoires, mais *les trajectoires* c'est un des éléments. C'est ça. Qu'on n'ait pas trouvé, avec le développement de compétences peut-être, comment on aurait pu mieux se rallier à un système de gestion intégrée de la performance... puis une stratégie[xlviii]. (Executive Manager)

This lack of strategic vision was also illustrated by several changes of direction in the introduction of SGIP.

> Donc, en juin 2015, on a eu quelque chose. En septembre 2015 on a eu un nouvel alignement parce qu'on est arrivé à ces réflexions-là. Plus tard, on a eu un autre alignement. Puis, il y a eu beaucoup de changements dans la façon de mener le projet. Moi je pense que ce sont les parties marquantes puis les parties difficiles de ces périodes-là. C'est que ce n'était pas tout à fait clair : qui pilotait quoi ? Puis c'est encore là aujourd'hui[xlix]. (Director)

Many believed that the integration would remove the barriers between the individual organizations. However, these barriers continued to exist. The transfer of best practices from one area to another was not happening, and hence the population

was not benefiting from the restructuration and the implementation of a management system.

> Je croyais, il y a 18 mois, qu'on aurait plus de facilité à s'inspirer des bons coups et en faire bénéficier toute la population du territoire. Ça, je pense qu'on n'y est pas arrivé du tout. […] Est-ce que c'est le défi de l'harmonisation, est-ce que c'est le défi d'organisation des équipes de travail ? Mais ça reste un défi. Des belles pratiques. Des bonnes pratiques à des endroits. D'amener ça ailleurs, c'est très difficile. J'aurais pensé que la fusion enlèverait ces obstacles-là. Non, ce n'est pas ça[1]. (Executive Manager)

This somewhat contradictory evaluation of the progress made towards the desired finality of SGIP may be more fully understood through the learnings discussed in the next section.

1.5.3. Key Learnings

The key learnings discussed in this section were generated through the analysis of the interview and group discussion verbatim and buttressed with observations noted in field journals. Refinement of the learnings to the form presented below occurred through iterative cycles of analysis and reflexive memo writing.

The learnings are loosely grouped around the concepts for eliminating chaos and creating an outstanding organization of Karen Martin. As you will recall from the narrative, Karen Martin spoke at the Lean Conference in May 2016. Following the conference, several elements appeared in the discourse of the CIUSSS de l'Estrie—CHUS in relation to the introduction of SGIP. The themes presented resonated with organizational members and provided a template for reflecting on the work that had been done to develop and implement SGIP.

The Important Role of Clarity

Clarity is one of the four causes of chaos, and one of the four conditions necessary for building an outstanding organization, as identified by the author Karen Martin. The author indicates that clarity refers to information and communication that

is unambiguous, relevant and honest. Several of the key learnings in this second action research cycle revolve around the importance of, and apparent lack of clarity: in the vision for, and the meaning of, an integrated management system; in the roles and responsibilities of the various participants in the development and introduction of SGIP; and in communication concerning SGIP. Another important condition for achieving clarity, and noted by research participants as being absent, is a clear idea of, and timely feedback on, organizational performance.

As was seen in the first action cycle, the meaning of, and vision for, an integrated management system was not widely shared. The lack of strategic direction noted in the qualification of progress may be explained by this confusion. For some, SGIP represents the embodiment of the management philosophy for the organization.

Business Excellence models build on this understanding and provide frameworks that align organizational design, strategy, systems and human resources to create long-term organizational effectiveness (Schulingkamp and Latham, 2015). In other words, SGIP to several members of the organization was viewed as a holistic, value-based user experience that required an integrated system of activities and processes. The system elements include a strategic vision for the organization with clearly defined objectives and priorities; leadership expectations; organization of work processes to provide value to the user; a workforce focus; a customer focus; and the appropriate data collection, analysis and knowledge management systems, all of which are interconnected and coherent and lead to continuous and sustained performance improvements.

Several of the activities of the CIUSSS de l'Estrie—CHUS point to a different understanding of what SGIP in fact was. During the early stages of its creation the interim director responsible for the Transformation Support Office led the development and adoption of various elements that closely resembled the dimensions of SPCHUS: a performance evaluation model was created; the patient trajectories were identified

and mapped; organizational priorities were identified; and a strategic Obeya was implemented. Under the responsibility of the DRHCAJ, the development of leadership competencies began. As these activities were taking place, the reflection and development of SGIP were transferred to a small team within the DAEPO using an A3 methodology. SGIP, as SPCHUS was previously, was thought to be the implementation of daily continuous improvement.

It is interesting to note that at the same time as the tactical team was reflecting with the researcher on the learnings of the past year, an article was published in the Journal of Hospital Administration describing clearly the distinction between a Lean Daily Management System (LDMS) and a Lean Management System. Daily continuous improvement, or LDMS, represents, "how individuals closest to the process at hand identify and solve problems every day […]. The objective of LDMS is to support daily operations at the frontline." (Taher, Landry and Toussaint, 2016, p. 90). An LDMS includes the use of visual controls, daily accountability processes, standard work for leaders, and discipline in the use of problem solving methodology throughout the organization (Mann, 2005).

An LDMS, however, is only one element of an integrated Lean Management System. Other important elements are missing. Elements such as: deployment of strategic objectives throughout the organization; organization of work processes around value streams (patient trajectories); focus on the patient and the value created for the patient throughout the organization; implementation of HR practices and policies that reflect a deep respect for people; identification of leadership competencies to be developed; and integration of an effective data acquisition and knowledge management system that supports continuous learning. These elements are documented in the vision of both SPCHUS and SGIP, but unfortunately, were not translated into actions taken within the organizations.

> Bien je pense que le fondement du système ça en est un. C'est une approche ou une philosophie ; c'est une façon de travailler qui aurait pu colorer tous nos dossiers depuis un an ; mais on l'a mis, à mon

> avis, comme étant un parmi les 19. Tu sais de faire 19 priorités, 19 A3 au printemps 2015, ça aurait été différent de dire que le système c'est notre façon de prioriser puis les 18 autres deviennent le filtre à travers. Le système filtre fait qu'on l'a traité comme tel. Probablement qu'il n'a pas eu son tour assez souvent pour en parler[li]. (Senior Manager)

> Le SGIP, je ne suis pas certain que les gens comprennent le *outcome*. Je ne suis pas certain que les gens comprennent le *outcome* ; et le *outcome* ne va pas arriver à la fin. Il arrive à travers tout, à tous les jours. Pas sûr que les gens comprennent tout à fait ça[lii]. (Director)

> En ce moment, les gens pensent que c'est une salle de pilotage. Mais on l'a beaucoup dit aussi. C'est qu'on donne toujours l'exemple de la salle de pilotage puis des stations visuelles. C'est réducteur, mais on est parti avec cette vision-là. On a donné ça comme focus et comme ton. Donc, c'est normal qu'on ait un ajustement à faire[liii]. (Director)

A lack of clarity is also evident in the roles and responsibilities of the various committees within the governance structure. The structure that was adopted did reflect some learning from the first action cycle in that the steering team was composed of senior executive managers and several directors. It was not, however, fully integrated in the functional governance structure of the organization. The role then of the directors involved in the piloting of organizational performance versus the role of those that did not left many perplexed. This confusion was not limited to the committees related to SGIP, but to the role of the various instances throughout the organization. If SGIP is thought to be an integrated management system, the governance structure and the roles and responsibilities of each of the instances naturally become part of the system.

> Bien, un des apprentissages c'est vraiment, une fois qu'on a décidé des éléments du système de gestion il faut qu'on s'habilite à le faire dans la structure de gouvernance et non pas en parallèle[liv]. (Senior Manager).

> Je trouve que le bureau de direction, des fois, il est beaucoup sur des éléments qui peut-être seraient de niveau moins stratégique que le bureau de direction. Quand je pense au bureau de direction, eux ils devraient donner des alignements sur, par exemple, comment les dossiers devraient cheminer ou devraient prendre des grandes

> décisions ; mais sans adopter des principes très particuliers qui selon moi devraient se faire plus au comité interdirection ou au comité directeur de SGIP qui est plus large. Je trouve qu'ils remontent beaucoup trop de choses au niveau du bureau de direction, mais bon… [lv] (Manager)

The specific committees in the governance structure for the project SGIP, experienced similar difficulties. The distinction between the role of the steering committee, the piloting of organizational performance, and the role of the tactical committee was ambiguous.

> Tu sais, c'est deux choses, puis là, c'est un peu mêlé ; les rôles sont un peu mêlés. Le comité tactique est interpellé sur des opérations régulières de l'établissement alors que son rôle c'est de s'attaquer aux lots de travail qu'on a identifiés pour faire le déploiement. Là, il y a des choses qu'on mélange. […] Pour bien départager ce qui est la structure permanente qui soutient un système de gestion. Puis, une structure temporaire qui est là pour le déploiement[lvi]. (Executive Manager)

> Les comités de gouvernance du système ont besoin d'être revus. Le comité directeur ; c'est difficile de faire la différence entre le comité directeur et le comité de pilotage. On mêle les rôles. Je ne suis pas sûr que le comité de pilotage pilote les affaires ; que ce soit lui qui devrait piloter. Je trouve que les hors-cadres, on aurait intérêt à piloter des choses qui sont de haut niveau. Mais qu'on se met à dire « as-tu un bon formulaire pour ; voyons les rendez-vous chez les médecins spécialistes ». On n'est pu *pantoute* à la bonne place dans ce temps-là[lvii]. (Executive Manager)

It is interesting to note that the roles of the governance structure for the project SGIP was similar to the way all of the projects were managed in the organization. The use of a steering team, tactical team and operational team was a standard template that worked efficiently from the perspective of many organizational members. This made it difficult for some to understand why the structure implemented for SGIP was not giving the results expected, again reflecting the discrepancy in the understanding of what it actually was.

> Agrément. On a mis sur pied la même structure. C'est les mêmes équipes qui les ont proposés une structure de projet. Comité

> prestation sécuritaire. Comité code d'éthique. On a fait la même chose pour les autres, mais il y avait un leader. Il y avait des équipes puis ça a fonctionné. Pourquoi celui-là ne fonctionne pas ? Puis moi je ne me retrouve pas dans ça[lviii]. (Director)

A lack of clarity is also noted in the communication within the organization. The mechanisms of communication, in general within the organization, are noted as being deficient (in the engagement surveys, in the workshops held in management forums, feedback in training sessions). The confusion around the meaning of SGIP, and unclear communication led to difficulties in understanding many of the decisions that were made concerning the management system, such as the identification of six patient trajectories or the choice of the directions that would pilot SGIP.

Actual performance levels, key to clarity, are not adequately communicated nor are the specific challenges that the organization faces. The administrative functions, whose role is to support the core operations, find it difficult to do so as it is not clear how and where they may help.

> Bien la sélection ; qu'il y ait eu une sélection tout court des directions. Puis, compte tenu des enjeux, il manquait l'aspect : oui ils ont fait leur planification annuelle, mais c'était basé sur des perceptions. Je veux bien croire qu'ils savent c'est quoi leur réalité, mais c'est justement ça qu'on veut, changer de dires. Va voir sur le terrain, va collecter des données. Va voir vraiment qu'est-ce qui fait mal. Fait que d'avoir fait le choix des directions en conséquence de ça, je pense ça aurait probablement aidé[lix]. (Professional)

Key performance indicators were difficult to identify for the organization, and performance was discussed in an anecdotal manner during the biweekly strategic Obeya facilitation. Organizational performance was discussed during management forums, but no indicators of performance were presented. Organizational priorities identified were not tied to overall strategic objectives for performance improvement. In addition, and vital to gaining clarity, spending time understanding and gaining insights from those closest to where value for the user is created was not part of the management practices.

In summary, lack of clarity on the meaning of SGIP for the organizational leaders and the committee members results in communication that is unclear and misunderstandings in the roles and responsibilities of the various instances within the organization. A lack of clear performance indicators makes it difficult to understand organizational performance and the organizational priorities. This lack of clarity undermines performance, is the cause of a lot of wasted time from clarifying information, or redoing work because expectations were misunderstood, and impacts the quality of decision-making. Achieving clarity is fundamental to the implementation of an integrated management system and achieving the transformation desired.

Two other fundamental elements concern focus (determining the few key priorities essential for organizational success and seeing them through to completion) and discipline (repeatedly practising desired behaviour until it becomes natural) (Martin, 2012). These two elements, identified as learnings by the research participants, will be explored next.

The Importance of Focus and Discipline.

Focus is defined by Karen Martin as the ability to determine the few priorities that are critically important for an organization. Too many priorities mean that resources are scattered, and a lack of discipline (difficulty in sticking with a project long enough to produce results) means that problems never really get fully resolved.

As seen throughout the narrative, the selection of organizational priorities, and the determination to see these priorities through until they are completed, was difficult for the organization. The seven priorities identified in January 2016, became four at a management forum in February. The strategic planning Hoshin Kanri exercise gave rise to 33 objectives, and 11 that were critical for the organization.

> Moi je pense qu'on soit encore trop éparpillé. Qu'on a encore trop de projets. Trop d'idées. Trop d'objectifs. Puis dans deux mois ça va être autre chose. Là, le ministère vient d'annoncer des budgets supplémentaires pour soutien à domicile, mais il n'est pas là. Il n'est

> pas dans... Moi je pense qu'on risque d'être — je cherche mon mot — d'être distrait de plein de choses[lx]. (Director)

> Mais d'accepter de prendre un moment puis de se dire « qu'est-ce qu'on fait, c'est quoi les 2-3 affaires qu'il faut vraiment changer », au lieu de tout regarder. Qu'est-ce qu'on pourrait, d'ici Noël, dire « ça, il faut qu'on change[lxi] » ? (Manager)

Choosing priorities means consciously not choosing others. The difficulty in prioritizing and limiting objectives to the critical few is driven in part by the fact that the environment is highly politicized; hence, the organizational image is extremely important. This pressure to be at the head of the class, in order to ensure funding, leads to setting objectives that are too ambitious for the capacity of the organization; and to a noticeable difference in the projected image versus the reality within the organization.

> Il y a des gens qui diraient qu'on a une grosse vitrine, mais pas de *back-store* OK. Fais qu'on vend plein de *patentes*, mais l'inventaire est vide[lxii]. (Executive Manager)

Building consensus is also an important part of creating and maintaining organizational focus. Consensus refers not to ensuring everyone is in agreement with the priorities chosen, but that organizational members, particularly those with ownership of specific priorities, have an opportunity to question and discuss them. Complete agreement is not necessary; understanding is (Martin, 2012). Lack of involvement in the determination of organizational priorities only creates the illusion of focus. While the process for determining priorities may be simpler and faster if determined by a small group of people, if the priorities are not understood and agreed upon, organizational members will be distracted by projects that they feel are more pressing for their function or service. As the narrative describes, organizational priorities were not determined through consensus. The first strategic plan, approved by the Board, was created by a very small group in the organization. The second attempt at creating focus, through the Hoshin Kanri exercise in June, involved a larger group of organizational members, however, consensus was not possible as many of the

directors were not involved. Given that the priorities were not understood nor agreed upon, maintaining focus over time was difficult for the organization.

The organizational environment of the CIUSSS de l'Estrie—CHUS is one of incessant activity; it is characterized by unpredictability, multiple external demands (MHSS and the media), a lack of time, and a lack of resources. Combined with this speed of action is a strong desire, as mentioned, to be the 'head of the class'. The progress that has been made in the reorganization in the space of only a year is impressive, as evidenced by the progress report of the organization after the first 100 days of existence described in section 1.4.1. Unfortunately, it may have come at the expense of coherence of action. The organization has difficulty, when deciding on priorities, imagining the long-term vision and questioning where the specific actions and decisions will lead the organization.

> Notre transformation est très influencée par le mode cahier de charge. *Check*! *Check*! On fait *check* sur des actions. Ça arrête après le *check*, nos patrons sont très pris dans ça. Il n'y pas une *case mesurer* et vérifier l'effet de l'action dans un mode toujours réaction[lxiii]. (Senior Manager)

> On se lance dans des choses qu'on n'a pas tout à fait comprises. Puis autant on le fait avancer ; mais on n'est pas prêt. Puis on est peut-être dans une culture qu'il faut tout faire en même temps. Ça revient au *vite vite*. Il faut tout faire puis c'est correct ; puis tout est parfait[lxiv]. (Senior Manager)

> La difficulté quand on part un projet ou on prend une décision est d'anticiper son cheminement dans l'organisation et de faire une boucle ; comme par exemple : les A3, les trajectoires. On fait une partie, mais on va faire quoi après. C'est comme si la décision de faire quelque chose est la boucle ; mais quand on décide x qu'est-ce qu'on va faire avec ; quand on décide quelque chose, on a l'impression que ça s'est fait — vision court terme. On semble être content de prendre la décision de faire quelque chose[lxv]. (Senior Manager)

The patient trajectories are cited as a classic example of this. Once the trajectories were determined and mapped, it was unclear how they would be managed

and facilitated in the future. And the relationship between the trajectories and SGIP was never really discussed.

Once priorities are determined, and focus is to some extent achieved in an organization, discipline, the ability to stick with a project long enough to produce results, is required. Discipline also refers to the systematic use of problem solving methods at all levels of the organization until it becomes second nature. Without this repetition and the discipline of seeing things through, outcomes are random, and root causes may not be found. Research participants indicate that the lack of focus combined with a lack of discipline explains the somewhat mitigated improvements in performance indicators.

1.5.4. Challenges

It is impossible to ignore the context and its influence on the adoption of an integrated management system. The adoption of a management philosophy, different in most respects to that which is dominant in the healthcare sector, is extremely demanding. With the reform, 4500 managers in the healthcare sector experienced changes in their role (and 1300 management positions were abolished). In most cases their responsibilities increased considerably, and their compensation decreased[68]. Bitterness, fatigue, resentment and resignation characterized their state of mind. The learnings presented, and the qualification of the progress made concerning the adoption of an integrated management system may not be illustrious, however, it is important to consider the conditions under which the organization was functioning. The audacity of the organization to implement fundamental changes in the organization of work processes, and in management practices, given the context of the reform is recognized. At the same time, there is the sentiment that the organization may not have been well equipped to execute this change, at this particular time.

> Peut-être qu'un jour la littérature le montrera, mais d'implanter un système avec un tel changement de culture pour tout le monde, dans

[68] Tribune La colère gronde contre Barette, le 27 février, 2016.

> un élément de fusion aussi importante ; il faut être très audacieux. Et je pense qu'on est parti en sandales et en culottes courtes et, comme dirait quelqu'un que je connais bien, il fait -20 dehors. Puis on pense qu'on va survivre longtemps, mais je ne pense pas qu'on est parti bien équipé[lxvi]. (Executive Manager)

> Le temps, la surcharge de travail. Le manque de reconnaissance des cadres du réseau par le ministère de la santé et des services sociaux puis la population. Tu sais, ça finit par teinter l'organisation qui n'a pas de pouvoir sur. Donc, la taille de l'organisation, le fait qu'elle est multi-site ; c'est quand on met ensemble le multi-site puis la non-reconnaissance de cette complexité-là par le ministère qui continue de dire qu'il n'y a pas eu de coupes en santé[lxvii]. (Director)

In this period, it is simpler for managers to concentrate on their own department or patient trajectory, and to feel in some small way in control of their actions, than to implement new practices in a matrix model of management.

> Les mois s'accumulent, la compréhension de ce que ça change dans le rôle qui s'accumule et la capacité d'assimiler le changement est très variable. Moins de 50% qui seront en mesure d'assimiler des changements de comportements maintenant. On est dans un contexte de contrôle élevé, tellement bombardé d'en haut. C'est plus simple d'être en silo, tellement de difficulté de gérer mon silo et à s'approprier mon nouveau rôle ; on a la misère de sortir à l'extérieur. Tout ce qu'on a réussi à faire à date c'est un constat. Je dirais étonnant, mais je dirais que les marches le plus difficiles à monter sont là depuis le mois de novembre. La réorganisation clinique s'est faite en février, à peine 6 mois qu'ils ont chaussé leurs nouveaux souliers. Les hors cadres sont pris avec une contre exemplarité constante ; et le poids de l'exemplarité et la volonté de changer sont partagés inégalement par les 15 directeurs. Tout le monde part de points différents en termes de compréhension. Tous les éléments ensemble ça fait qu'on vit des up and down[lxviii]… (Director)

Another key challenge for the organization is the required outward focus. With the abolishment of the regional health authorities, the PDGs are in interaction directly with the Ministry. In addition, prior to the reform, senior managers of each of the establishments were responsible for maintaining relationships with communities and other public organizations involved in the regional networks (schools, municipalities,

etc.). With the integration of the health network, this responsibility falls on the Executive managers, a group far smaller in number than previously.

> Bien ça me dit, comment elle s'appelle ; que la priorité n'ait peut-être pas — dans l'ordre des priorités — améliorer notre manière de faire. Ils ne sont pas prêts à sacrifier le temps pour y arriver. Donc, ils continuent à répondre aux besoins extérieurs et puis, ils n'ont personne de stratégique qui est responsable un petit peu de l'efficacité de l'organisation à l'interne. Selon moi, ils sont plus concentrés pour répondre — maintenant qu'il n'y a plus d'agence, à la pression externe[lxix]. (Professional)

> Ça prend ce que j'appelle quelqu'un qui prend le bâton de pèlerin et qui, à toutes les occasions, est cohérent et cohésif. Puis il influence les gens autour. Je pense qu'on n'a pas eu cette personne-là avec un niveau stratégique suffisamment élevé pour être en mesure d'influencer au bon niveau, pour ouvrir des portes pour le [comité] tactique. Pour dénouer. Et je pense qu'on a un enjeu là[lxx]. (Senior Manager)

The key learnings combined with the challenges identified were the basis for the proposed adjustments which are summarized next.

1.5.5. Suggested Adjustments

These learnings were discussed at a tactical team meeting in mid-October. The tactical committee decided to limit the analysis of the learnings and recommendations to be presented to the Steering Committee to the challenges faced in the governance structure for SGIP. The team prepared a summary document of the original roles and responsibilities of each of the committees in the governance structure, presented previously in the narrative (see Table 10), highlighting several of the issues raised in the key learnings concerning the current structure, as well as presenting several questions to stimulate reflection and discussion of the Executive Management Committee. The tactical team requested that the EMC provide a new orientation for the governance of SGIP and introduce more efficient mechanisms within the management system that would allow for issues to be raised and addressed systematically. The following are the elements that were highlighted:

A. La structure de gouverne SGIP n'est pas appliquée (expérimentée seulement 2 mois). Les comités directeur et tactique devraient être des moments d'échanges sur les enjeux entourant le déploiement SGIP vs la préparation des communications pour forum, CCI, etc. [lxxi] ;
B. Il n'y a aucun porteur clairement défini pour le SGIP. Est-ce que le porteur est le bureau de direction, le comité directeur ou le promoteur de SGIP ? Quels sujets devraient être abordés au comité directeur vs au bureau de direction[lxxii] ;
C. Les rôles de certaines instances ne sont pas appliqués. Il n'y a peu de place pour discuter des liens entre les lots de travail et l'escalade des enjeux au comité directeur[lxxiii].
D. Pas d'exécutif du comité tactique[lxxiv].

The questions for reflection and discussion included in the summary document included the following:

A. Est-ce que le modèle de la structure de gouvernance en place est adéquat ex. : logique de gestion de projet pour déployer le SGIP[lxxv] ?
B. Que doit-on traiter dans les instances de projet versus les instances organisationnelles[lxxvi] ?
C. Quels mécanismes doit-on formaliser pour escalader les enjeux[lxxvii] ?
D. Quel temps dédions-nous aux rencontres pour échanger sur les enjeux du déploiement (lien avec le rôle 2 du comité directeur) [lxxviii] ?
E. Comment peut-on s'assurer que les demandes sont adressées de façon claire, par la bonne personne, à la bonne personne ou instance et au bon moment[lxxix] ?
F. Quelles modalités met-on en place pour faire transiter le comité de pilotage vers le comité de coordination interdirections[lxxx] ?

These elements were presented to the PDGA and the director of the DQÉPÉ in late October 2016. The PDGA then raised the issues with the Executive Management Committee at a subsequent meeting. The steering team meetings for SGIP were cancelled during the period that the EMC reflected on the governance structure and changes to be made. One steering team meeting was held at the end of November to review progress in the deployment. No mention was made by the Executive managers on the reasons behind the cancellation of the steering team meetings, and no information was provided on discussions concerning the governance structure.

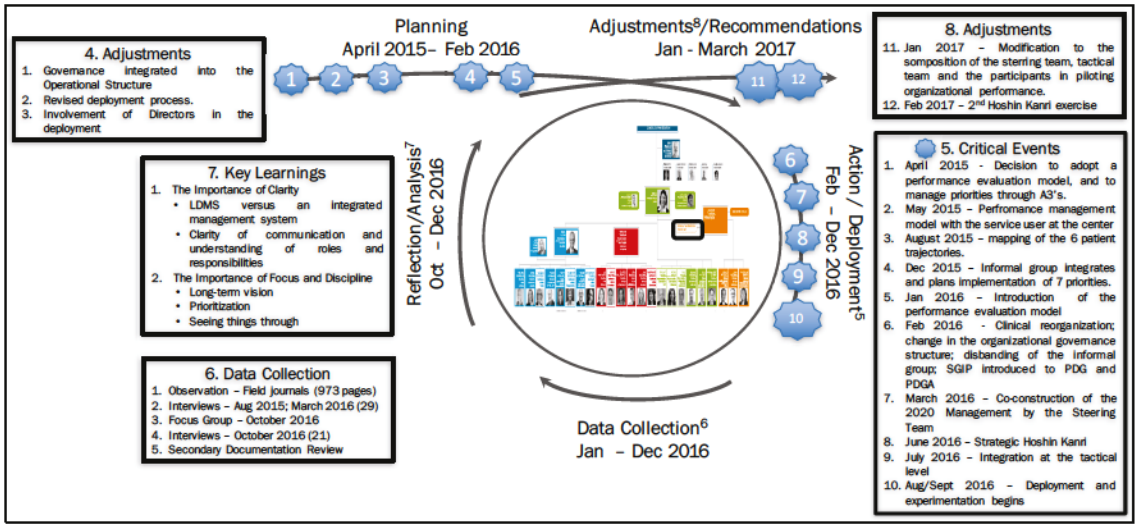
It was not until January of 2017 that the Executive Committee announced to the steering team the results of their reflection and the adjustments that were to be made concerning the governance of SGIP. First, the EMC would become the Steering Team for SGIP. The tactical committee would continue in its current form, and the directors of functions involved in deploying SGIP would be present for the tactical committee meetings. Second, the PDGA would remain the sponsor of SGIP. And finally, performance management through Obeya would involve the entire inter-direction committee (CCID). These adjustments took effect in February of 2017. It was also announced at this time that the patient trajectories would no longer be included as a project 'lot' under SGIP but would be managed separately under the sponsorship of one of the DGA's. Also removed from under the umbrella of SGIP was the co-management model for clinical services.

In February, the organization embarked on their second Hoshin Kanri exercise. For the 2016–2017 exercise, all directors participated, and several changes were made in the process based on the learnings from the previous exercise.

1.6. Summary of the Second Action Research Cycle

A schematic summary of the second action cycle is presented in Figure 26 below. The summary begins with the adjustments made based on the learnings of the first action cycle (the 4th item in Figure 19 is reproduced here, hence, the numbering of the items in this figure continues on from the previous action cycle), and then details the critical events, key learnings and adjustments following the second action cycle. The second cycle is characterized by the rapidity of action, the implementation of various tools and models, and a search for coherence of action. Much of the action was managed from above; directives from the Ministry concerning the reform, and the perception inside the organization that the reorganization was very much executed in a top-down manner.

Figure 26
Summary of the Second Action Cycle



2. SYNTHESIS OF THE ACTION RESEARCH CYCLES

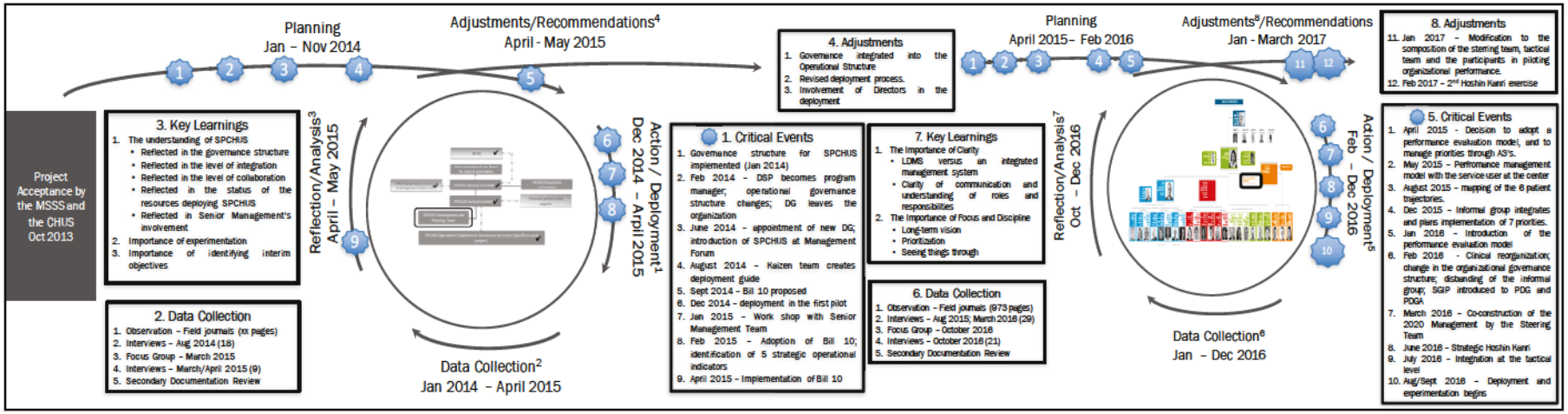
Over the three-year period of this study, two action research cycles were completed. The first with the Development and Planning Team for SPCHUS at the CHUS, and the second with the tactical team for SGIP at the CIUSSS de l'Estrie — CHUS. Each of the cycles involved a planning stage, a deployment stage, a period of reflection and analysis, followed by recommendations for adjustments for future deployment. Data collection was performed continuously throughout these cycles. Figure 27 provides a schematic summary of the cycles, including the critical events, the data collected and used for the analysis, and the key learnings of the research participants of each of the cycles.

Over the two cycles we can see an evolution in the understanding of the meaning of an integrated management system rooted in a lean philosophy. The learnings from the first cycle were used to identify adjustments for a second cycle. There were several challenges with this transfer given the period of turbulence caused by the reorganization of Healthcare services in Quebec following the adoption of Bill 10. Several participants in the first cycle do not believe that the learnings were considered in the development and deployment of the management system in the

second cycle. This perceived lack of transfer of learning provides insight into the level of learning during the research period.

In looking more closely at the learnings and adjustments, it may be noted that the changes made were behavioural modifications or adaptation to changes in what was going on in the environment and the organization. They may be considered as changes or refinement of existing routines. The participants reproduced in the conception and deployment of the integrated performance management systems at both the CHUS and the CIUSSS de l'Estrie—CHUS precisely the practices that they were trying to change. The key elements that contributed to this are discussed in the following section.

Figure 27
Summary of the Action Research Cycles



2.1. Key Elements Shaping the Design and Deployment of an Integrated Performance Management System

The design and deployment of the integrated performance management system over the two cycles were shaped by the following elements: the understanding of what an integrated management system was; a high degree of instrumentalism; and the bureaucratic nature of the organization. The understanding of the meaning of an integrated performance management system was a key learning of both action research cycles. The meaning that organizational members gave to the system affected how the introduction was managed and led to several issues in communicating the intention and in determining the roles and responsibilities of various actors in its design and development. As this was discussed in some detail in the key learnings of the second action research cycle in section 1.5.3 of this chapter, we will focus attention here on the two other elements that shaped the introduction of both SPCHUS and SGIP.

Instrumentalism: Utilitarian Nature of SPCHUS/SGIP and an Emphasis on Carrying out Steps

One of the themes concerning the learnings from the development and deployment of SGIP concerns the high degree of instrumentalism. The instrumentalism is characterized by: an emphasis on carrying out various steps and implementing tools; an emphasis on conceptual work—developing models—instead of on experimentation; leadership positioning themselves outside of the desired changes; and the search for the 'one best way' (Alvesson and Svengingsson, 2008). Research participants indicated that the conception and deployment of the integrated management system in both organizations manifested these characteristics.

The list of tools that were implemented, under the banner of both SPCHUS and SGIP, was impressive. A standard agenda, problem solving A3s, and a performance evaluation model (balanced scorecard) were all introduced very early in the reorganization at the CIUSSS de l'Estrie — CHUS. Within the CHUS, detailed models had been developed for evaluating patient experience, for managing change, and for

deploying SPCHUS. It appeared that the tools took on a heightened level of significance, as if the tools were the substance of lean (Waring and Bishop, 2010). The purpose of these tools and models, how they would help the organization to meet its objectives, and how they fit within the organization's management philosophy was, unfortunately, not clear.

> Non. C'était comme c'est de l'acquis. Tout le monde sait de quoi on parle. C'est comme l'horaire synchro : quand on a descendu l'horaire synchro le monde disait « à quoi ça sert ? Ça va aider quoi ? » Tu sais le sens-là. […] Le sens des affaires, il y a des gens qui travaillaient. Je me souviens de la première conférence. Le premier avril 2015, madame Gauthier a fait sa conférence, c'était très bien. Je trouve qu'il y a eu une communication le 1er avril, avec tous les gestionnaires. Ça, c'était A+. Mais de voir — moi j'étais à l'institut — de voir les yeux du monde quand elle a dit : « bien là on a fait un A3 sur la transformation ». Hein ? On va faire notre A3 et tout ça. Tout le monde dans la salle : « de quoi qu'elle parle ? » Personne ne comprenait rien. Ça, c'est sûr, mais on partait de 15 organisations et nous autres des A3, personne ne parlait de ça. Il y avait de la résolution de problème pareil, mais pas avec cette pensée A3 ; qui est super intéressante, mais il faut l'expliquer la démarche de pourquoi on fait ça. Fait qu'on a descendu des affaires des fois ça n'avait pas son sens[lxxxi]. (Manager)

> Là on est encore au moment où on dit « bien on déploie, ça va être ça » ; mais on n'a pas le sentiment encore que c'est omniprésent et que ça fait partie de l'ensemble dans nos discussions puis nos décisions[lxxxii]. (Director)

> On a parlé plus de projet, mais pas de qu'est-ce qu'on veut faire avec. On a parlé beaucoup des A3, mais pas des priorités en arrière des A3. C'est comme le moyen prime sur le sens en arrière[lxxxiii]. (Senior Manager)

> On valorise les outils, mais comment ça va marcher après le dépôt de l'outil n'est pas discuté et n'est pas valorisé. C'est au travers de ce qu'on va faire avec les outils qui sont importants dans la transformation[lxxxiv]. (Manager)

The organizational priorities resulting from the Hoshin Kanri exercise are another example of an understanding of SGIP as a collection of tools, a series of steps

to be implemented. How the priorities would be used to guide action and manage performance in the organization was not clearly explained (or understood)[69].

> L'autre élément marquant, ça a été les objectifs annuels stratégiques. Je pense que ça aussi ça a été un élément marquant. Quoi qu'on a eu beaucoup de difficultés à communiquer, OK. On a fait le travail, mais la communication de ça a été fort déficient[lxxxv]. (Executive Manager)

Outside of the deployment in the pilots at the CIUSSS de l'Estrie—CHUS, once the priorities had been communicated, they were not integrated into organizational communication. They did not become the framework through which management meetings nor statutory meetings were structured across the organization. Numerous other examples of simply carrying out steps may be found in the narrative: the determination of key indicators at the CHUS for deployment across the organization was completed in approximately 10 minutes; the evaluation of lean maturity with the senior management committee with no time for discussion on the various elements being evaluated; the creation of the vision statement at the CIUSSS de l'Estrie — CHUS ; the completion of the A3s for the 19 priorities; and the mapping of the trajectories. It is, however, recognized by at least one member of the Executive Management Committee that the deeper roots of the system should have been explored.

> C'est ça qui est arrivé. Il fallait se développer. Il fallait déterminer les ambitions. Il fallait déterminer les valeurs. Il fallait déterminer la formation. Il fallait déterminer les compétences. Ça, malheureusement ça nous rattrape aujourd'hui parce qu'on ne l'a pas fait là. Puis moi je continue de trouver ça dommage qu'on ne l'a pas fait[lxxxvi]. (Executive Manager)

Another characteristic of instrumentalism exhibited over the research period was a focus on the conceptualization and design rather than on experimentation and

[69] This was also noted within SPCHUS. As seen in the narrative the strategic operational indicators were determined by the Senior Management Team in approximately ten minutes. Following the meeting senior managers were not sure if these indicators would be used in the pilots or would be deployed throughout the organization.

action. This was noted in both action research cycles as a source of frustration for the participants.

> Je viendrais tronquer toute la sophistication puis tous les modèles et les concepts puis les affaires compliquées puis ce serait des toutes petites expériences sur le terrain dans l'action. On passe tellement de temps à discuter puis à avoir un plan de si, plan de gestion de changement, plan de toute. C'est incroyable[lxxxvii]. (Senior Manager)
>
> C'est comme si tu ne peux pas transférer une conviction puis une expérience par les mots. Ça ne passe pas. Il faut que ce soit fait dans l'action[lxxxviii]. (Manager)
>
> On a atteint la capacité maximale de ce que cette structure-là pouvait nous faire vivre. Puis je parle principalement du comité directeur puis du comité tactique. On a de la difficulté aussi, au-delà de sortir des concepts, on peut en trouver des concepts, mais de les appliquer[lxxxix]. (Executive Manager)
>
> On reste dans une structure de projet et on voit peu de gens capables de transposer les concepts dans la réalité quotidienne. C'est là que je pense qu'on a de la difficulté[xc]. (Executive Manager)
>
> Qu'on a de la misère à le faire lever le système ; au sens d'aller plus loin que d'expliquer ce que c'est. On a de la misère à l'incarner. On a de la misère à aller plus loin que d'expliquer ce que c'est. On dirait qu'on ne rentre pas dans « on va le faire, le vivre[xci] ». (Senior Manager)

One of the reasons for the difficulty in moving from conception to experimentation may be the positioning of senior leaders, in general, outside the change and the resulting lack of role modelling of the desired behaviours. This positioning may be seen from the very first 'kick off' of SPCHUS at a management forum in June 2014, where the senior managers discussed the changes required of managers in the organization. It is also reflected in the numerous management forums at the CIUSSS de l'Estrie—CHUS where managers are encouraged to question the ways in which the system will require modifications to their management practices, yet executive leaders do not discuss the ways in which their practices will change.

> Il faut qu'il y ait un soutien de la haute direction, de la direction générale ; puis ce soutien-là ce n'est pas un soutien théorique. Il faut qu'il y ait un soutien pratique[xcii]. (Executive Manager)

> Mais s'il n'y pas un volume de personne qui fait l'effort, on ne verra pas le changement. Et les gens ils nous regardent, après ils imitent. Si tu dis oui, on a un système de gestion, on s'est donné des priorités, on va renoncer ; mais qu'ils ne te voient pas, ils n'ont aucun changement à prioriser. Ils voient le renoncement à rien. Il n'y a rien qui a changé dans tes rencontres statutaires ; il n'y a rien qui change dans les rencontres de gestion : bien il faut qu'on admette qu'il n'y a rien qui a changé[xciii]. (Manager)

Change at the most senior level of the organization is noted as being difficult, and as having an impact on the change throughout the organization.

> Je te dirais le bureau de direction n'a pas été capable de moduler ses processus en fonction du SGIP encore. Ok. La façon dont on gère l'organisation dans le bureau de direction ; on n'a pas été capable de passer cette étape-là. Comment on pilote nos priorités à nous ? Nous, du bureau de direction, comment on assure le suivi sur nos indicateurs. Quels dossiers on amène ? On a des dossiers très stratégiques et des dossiers très, très opérationnels qui ne devraient jamais arriver là. Fait qu'on reste dans un mélange de ce qu'on a toujours connu. Fais qu'on n'a pas réussi à passer cette étape-là[xciv]. (Executive Manager)

> Fait que si cette entité-là, qu'est le bureau de direction, n'est pas capable de se modifier en conséquence, c'est sûr que les gens doivent le sentir sur le terrain puis ailleurs autour de nous. Tu sais qu'il y a une incohérence dans tout ça[xcv]. (Executive Manager)

The comments of participants in the action research indicate that for the transformation to occur, the organization needs to move from the development of models to experimentation; from discourse to action. As frequently documented, exemplarity of hierarchal superiors is an important part of change, and takes a considerable amount of effort.

> Le changement doit être porté par chacun de nous puis ça prend des efforts énormes parce que tu ne te le répètes pas toi-même de dire : OK parce que tu sais, moi aussi j'aurais pu tomber dans le piège. Je me le répète à tous les jours. Attends un peu là. T'as fait ça, OK. Ça

> change quoi dans ta journée d'aujourd'hui ? C'est qui je vois aujourd'hui ? C'est quoi qui est planifié ? Alors là j'ai une rencontre jeudi prochain. Attend minute je ne peux pas. Ah, j'ai ma première table des chefs depuis que j'ai fait ça. Mes chefs de département ne sont pas encore nécessairement au courant de ça, mais comment je pourrais les préparer à c'est quoi que je change dans mes statutaires ? Je suis toujours en train de demander ce qu'il faut que je change pour être en cohérence avec notre système de gestion. Tout le temps[xcvi]. (Director)

Despite the general perception that the most senior leaders had positioned themselves outside of the change, there is evidence of the realization that the change is also required at their level of the organization.

> Des fois on peut se dire comment ça se fait qu'ils ne l'ont pas fait. Si on s'arrête deux minutes c'est souvent parce que *nous* ne l'avons pas fait. Alors, tu sais, je peux bien faire concerter, mais est-ce que moi je suis en situation de concertation avec mes confrères[xcvii] ? (Executive Manager)

> Dans un système quand on veut changer en tout ou en partie quelque chose, il faut bien reconnaître qu'on fait partie du système[xciii]. (Executive Manager)

> Et l'autre chose que j'apprends aussi. Tu sais quand on veut provoquer un changement chez quelqu'un il faut accepter que ça amène un changement chez soi[xcix]. (Executive Manager)

The final manifestation of the high degree of instrumentalism is the incessant quest for the 'one best way', a universal solution that may be applied to resolve organizational issues. Throughout the period of the research study there were examples of the organization looking for an expert solution instead of learning from their own experimentation and actions. Tools and solutions were adopted, without necessarily thoroughly understanding the issue to be resolved. Examples of this include the A3s and Gemba walks that were adopted following a benchmark visit to Thedacare, and the principles of Karen Martin concerning the creation of an outstanding organization adopted in the organizational discourse following a Lean Conference.

> Puis on est souvent ; on a souvent tendance au niveau stratégique, à suivre la mode du moment. Que ce soit [M. Tel], on va retransformer par des sources extérieures notre manière de parler[c]. (Professional)

The high degree of instrumentalism is one of the characteristics of bureaucracy. As we will see in the next section, the bureaucratic nature of the organization was another key element that shaped the design and deployment of the integrated management system at both the CHUS and the CIUSSS de l'Estrie— CHUS.

The Bureaucratic Nature of the Organization

Bureaucracy embraces logic, rationality and efficiency. Weber's model of bureaucracy is characterized by "a division of labour—vertically and horizontally—including the separation of conception and implementation, instrumentality, a limited focus, a strict chain of command, and a focus on following rules and delivering specific behaviours." (Alvesson and Sveningsson, 2008, p. 127). These authors also note that a key characteristic of bureaucratic organizations is incessant action.

One of the main characteristics of bureaucracy is a division of labour. This may be seen throughout the research study: the delegation of responsibility for the A3 management to specific functional areas; the partitioning of the elements of SGIP and SPCHUS into project 'lots'; the separation of the roles of the committees in the governance structure (the strategic level decides, the tactical level provides orientation, and the operational level executes); and confusion surrounding the role and responsibilities of the DQÉPÉ, the Transformation Support Office and the DRHCAJ concerning organizational development; to name but a few. The perspective of the organization that this is the most efficient way to organize the work makes it very difficult to integrate various elements of the management system, and to have a holistic, systemic view of the organization.

> Quand tu travailles dans tes lots, puis que t'es dans ta direction, puis que t'as le contrôle sur tes ressources, tu sais je pense que ce bout-là t'es capable, tu peux le contrôler. Tu peux affecter les ressources en fonction de ton équipe, en fonction des objectifs qui sont tactiques.

> Mais quand ça dépasse la responsabilité puis l'imputabilité de ma propre direction puis que tu ne trouves pas les leviers… le pouvoir c'est là. Je pense qu'on est rendu-là. C'est pour ça que c'est plus difficile. Parce que c'est là qu'on est rendu[ci]. (Manager)

> Là, on a une recherche-action sur la collaboration. On n'est même pas capable encore de voir quels liens vont se faire avec notre système. Ça travaille encore à part. Ce n'est pas travailler comme si ça faisait partie de la gestion. C'est un piège qu'on a encore. Ça ne va pas bien, mais on dirait qu'on ne le fait pas de façon intégrée[cii]. (Manager)

Difficulties in integration and system thinking are notable throughout the narrative. Both the committee working on the organizational identity and the team developing SGIP were trying to develop a way that key initiatives could be organized in a coherent manner. An informal group was created to fill this void and to organize the key activities to be implemented during the period of the clinical reorganization, despite the existence of a coordinating committee of the Transformation Support Office.

Division of labour also often leads to the separation of conception and implementation, as each of these activities would be the responsibility of different groups in the organization. This is seen very clearly with SPCHUS. The entire program had been developed prior to being passed on to the Development and Planning Team to determine the implementation strategy. This is characteristic of many change management models, where change is orchestrated by organizational leaders, and it is then passed down to others in the organization, similar to baton passing in relay races (Alvesson and Sveningsson, 2008).

A clear vertical division of labour was also manifested in the presentation and decision-making concerning organizational priorities managed through A3s. In both the CHUS and the CIUSSS de l'Estrie—CHUS, following the presentation of progress concerning a specific priority, including specific issues and challenges, the project owners were requested to leave and decisions and actions were finalized by senior

leaders. This vertical division of labour also points to a very clearly defined chain of command. Combined with a traditional view of the role of management as PODC, it is a 'Top Down' and autocratic perspective of management. The vision of management that is represented in the integrated performance management systems within both organizations requires a much more participative nature, or 'Bottom Up' style of management. There is apparent confusion in the organization on the distinction between these two approaches, as seen in the narrative of events.

In a top-down approach the role of leadership is one of control; in a bottom-up approach it is one of facilitation. In a pure bottom up approach, leaders let the front-line workers foster the mindset and the initiative. Toussaint (2015), provides a more nuanced approach, defining the bottom-up approach as frontline teams having "clear decision-making authority" and exercising it "with the knowledge of what upper echelons of management are trying to accomplish." (p. 4). In this definition, bottom-up does not mean relinquishing the definition of the vision for the organization, and letting it emerge from lower levels of the organization. Nor does it mean simply listening to what subordinates have to say, and then making a decision at higher levels of the organization. Taher *et al.* (2016), describe this more nuanced definition as middle-out approach, whereby the role of middle managers is critical as they are well positioned to affect change in both directions in an organization through daily interactions with front-line staff and with senior leaders. It does not, however, mean that senior leaders do not need to develop the mindset and build the capacities necessary for role modelling the behaviours, and influencing meanings within the organization.

The deployment of the integrated performance management systems in both the CHUS and the CIUSSS de l'Estrie—CHUS was a contradictory mix of a top-down and a bottom-up approach. Many of the changes implemented in the integrated organization following the implementation of reform were made using an autocratic, 'push' style management, an approach clearly incongruous to the management philosophy behind

desired changes. This is recognized by one member of the Executive Management Committee:

> Tu sais, c'est de passer du *top down* au *bottom up*. Il faut qu'on ait des gestes cohérents pour amener au *bottom up*. C'est ça qui était le plus incohérent dans la dernière année. En même temps, on se donnait une philosophie de gestion et c'est ce qu'on souhaitait. En même temps, ce n'est pas ça qu'on faisait ; mais ce n'était pas ça qu'on faisait dans un contexte de restructuration majeure puis on ne l'a peut-être pas exprimé. Alors on n'a pas pris le temps de le dire, on n'a pas pris le temps ; c'est peut-être ça qu'on aurait dû faire. D'intégrer le modèle et dire c'est le modèle qu'on vise et y arriver progressivement. Si on avait pris le temps d'expliquer davantage tout ça[ciii]. (Executive Manager)

At the same time that decisions and changes were made top-down, executive managers were leaving the development of the vision of the system, and development of key messages at organizational forums to intermediate level managers.

> On a retravaillé, retravaillé, retravaillé ; mais ce n'est pas facile. C'est ça. C'est qu'on travaille à rebours. Comment ça se fait que nous, comme direction, comme DRH (?) on va vous soutenir, on va vous organiser ça, si vous voulez des conférenciers on va en trouver ; mais dites-nous qu'est-ce que vous voulez dire à vos gestionnaires. Ce n'est pas nos gestionnaires, c'est les vôtres. Qu'est-ce que vous voulez partager ? Moi je trouve que le bureau de direction ne joue pas bien son rôle de leader. Ce qu'il fait, c'est qu'il fait de la microgestion sur bien des affaires ; mais il ne nous insuffle pas la mobilisation, la motivation, l'orientation, la vision. Ils attendent qu'on les nourrisse. Ils critiquent, embarquent, ne sont pas sûrs[civ]. (Manager)

> On a l'impression qu'on[70] devrait porter la vision ; elle devrait être portée par la direction[cv]. (Manager)

Despite leaving the definition of the vision to the intermediate level managers, in particular the tactical committee of SGIP, there was little follow-up on the progress in terms of key challenges and obstacles that require resolution; nor in terms of learnings from experimentation. The tactical committee was left to determine key

[70] Referring to the tactical team

organizational messages, and at the same time, were told what needed to be done next by senior leaders.

> On ne gère pas. Tu sais les comités tactiques travaillent beaucoup, mais on dirait qu'il y a beaucoup de choses qui s'arrêtent là. Puis le bureau de direction, on dirait qu'on ne regarde pas ce que le comité tactique a fait. On regarde d'autres affaires. Puis on dit au comité tactique « il faut que vous fassiez ça[cvi]. » (Director)

The role of leadership in a bureaucratic environment is one of control. Several events over the period of the study illustrate very clearly a discomfort with a participative style of management. The informal group that was planning and coordinating the various priorities prior to the clinical reorganization was halted, and the responsibility returned to the Steering Team for SGIP; the integration of Lean and Planetree was not permitted within the SPCHUS Development and Planning Team and was repatriated by the interim director of the Transformation Support Office; and the steering team responsibilities for SGIP were transferred to the Executive Management Committee.

> C'est symptomatique. Mais ce n'est pas comme ça que ça a été vu. Puis là bien ça a été ; ce qui est un réflexe normal de tout le monde. Ça revient tout le temps quand t'as peur de perdre le contrôle bien *oups !* tu le remontes en haut. Fais qu'on l'a remonté[cvii]. (Director)

In summary, the high degree of instrumentalism and the bureaucratic nature of the organization were two key factors that influenced the development and integration of an integrated management system in both organizations. These factors combined with the understanding of an integrated management system of the most senior levels of management explains the perception of participants that the organization was lacking both a long-term vision, and an integrated view of the various organizational elements and how they fit together. The images that participants used to represent the organization, noted in the final interviews, illustrate this perception clearly: a puzzle without an image on the box (manager); a body with no neck (the head is not attached) (senior manager); dense fog that we must feel our way through (professional); and a fleet of boats during a violent storm with the admiral ship nowhere in sight (manager).

3. THE PROCESS OF LEAN TRANSFORMATION

Having looked at the key elements that influenced the design and introduction of the management systems at two healthcare organizations, we will now turn our attention to what can be learned from the attempts at a lean transformation. The briefing, commissioned by the Conference Board of Canada and introduced in chapter 2, provides a framework for conceptualizing a lean journey (Mackenzie and Hall, 2015). The three levels identified in the briefing speak to evolution in the understanding of lean. A summary of the characteristics of the levels of transformation may be found in Table 12.

Table 12
Levels of Transformation

	Tool Driven	**System Driven**	**Philosophy Driven**
Description	Using specific methods to create point solutions	Structuring tools into a system context	Embedding principles in a management system
Objective	Problems or quick improvements in productivity or efficiency	Goal—oriented improvements	Creation of a Learning Organization
Response	Reactive	Strategic, Proactive	Autonomous
Leadership	Sponsor	Champion	Coach/Support
Scope	Department or Service	Program	Organization
Target	Processes	Patient Trajectory	Organizational Meaning

Adapted from Mackenzie, J., and Hall, W., 2015, Mapping the Journey: Success and Failure with Lean, Ottawa: The Conference Board of Canada

At the first level, lean implementation is tool driven and the target of change is organizational processes. At the second level, implementation is system driven and targets patient trajectories, while at the third level lean is viewed as a set of principles or a philosophy targeting organizational meaning. The behaviours and attitudes required at each level are notably different. At the first level, initiatives are deployed in a usually reactive manner and are unconnected to an overall guiding strategy; projects are managed individually; there is an absence of senior management

involvement; and conception is delegated to middle levels of the organization. Organizations realize after starting with a tool-driven approach level that obtaining any kind of sustained or continuous improvement in performance is limited. The identification of performance indicators becomes important for identifying areas where the improvement tools should be deployed, and senior managers usually become more involved as they realize how a strategic view would help in sustaining performance improvements.

Moving to a system driven approach, senior managers begin to have a more systemic view of the organization and begin to look at their organization in terms of value streams (patient pathways or trajectories). The concern shifts from improving the efficiency and productivity of specific services, to looking across the pathway for ways to improve value to the service users. An organization at this stage of their journey would define strategic goals and objectives, and direct efforts and improvements to areas that will help them to meet these. Senior organizational members in these organizations are committed and have a thorough understanding of lean as a daily management system. Organizations at this stage use Hoshin Kanri to determine strategic objectives and deploy these throughout the organization. A lean daily management system is tied to the strategic objectives and permits the organization to improve key indicators daily, thus moving the organization closer to attainment of their goals. In an environment where the strategic goals are clear, there is movement away from managing in silos (improving performance within individual sectors) to collaboration across vertical and horizontal boundaries to collectively improve organizational performance. Leaders and managers at this level spearhead initiatives and demonstrate the key desired behavioural changes. As noted in Chapter 2, achieving this level in a transformation to a lean philosophy is noted as being extremely difficult in public healthcare (Mackenzie and Hall, 2015). The shift from siloed to value stream thinking; from a short-term to a long-term perspective; and from an autocratic to a servant style of leadership are noted as being particularly difficult (*Idem*).

At the philosophy or principle driven level, the philosophy of lean is embedded in an integrated management system, and manifestations of the philosophy are seen in daily actions. At this stage of transformation, the organization is characterized by holistic thinking, transparency, and the ability to learn through reflection. Double loop, or second level learning may be observed (as opposed to first level or single loop learning considered to be behavioural adaptation). There is a shared understanding of the organizational vision, and long-term commitment to the two fundamental pillars of lean: continuous improvement and respect for people. As mentioned in Chapter 2, one of the facilitating factors for lean implementation is aligning the espoused value of respect for people with the inferred values demonstrated through behaviour. Examples of these behaviours include investing in training and development, physical presence and involvement in activities and demonstrating that, while the ultimate goal is to improve patient outcomes, this is done by improving the working conditions of those providing the services (Drotz, *et al.*, 2014; Radnor *et al.*, 2012).

The journey through these stages is not linear, and all members of the organization may not be at the same stage at the same time. The scientific literature does agree that those that take a philosophical view of lean experience greater sustainability of outcomes by the fourth or fifth year of implementation than those that take a tool-based approach. Most organizations start with the tool-based approach, but given its limitations move to a system or a principled approach to lean.

The framework of the briefing is an interesting template to analyze the intention and the process of change of the implementation of an integrated management system based on Lean principles. The learnings of the two action research cycles illustrate the non-linear nature of a transformation through the different levels. Recall that the experience of the CHUS led them to a vision of transformation described in the project SPCHUS. The limitations of a tool driven view of lean were recognized, and the vision clearly indicates a desire to move to a system driven level. However, the data collected during the research project indicates the role of leadership largely remained one of a

sponsor, response was still mostly reactive with movement towards a more strategic and proactive approach, and the scope in the deployment was still at the program level (with substantial effort to move to patient trajectories).

The development and deployment of SPCHUS, which represented a Lean Daily Management System was not championed by senior levels of the organization but by the Development and Planning Team, was not connected in any way to the development of patient trajectories and was detached from the strategic and operational plan of the organization. The work of the Development and Planning Team led to the introduction of strategic operational indicators, and efforts were made to connect the programs where SPCHUS was being piloted to these organizational indicators to facilitate overall organizational performance improvements.

In the second cycle with SGIP, the tactical committee's understanding of an integrated management system shows signs of moving from a system driven approach to a philosophy-driven approach. The language used to describe SGIP, and the desired changes in the organization, reflect an intention of transformation at this level. Within the steering team, however, understanding of the intention is at the system-driven level. SGIP is still not integrated with the deployment of patient trajectories. While several of the executive and senior directors remain in the role of sponsor, some (particularly those involved in the pilots) show signs of evolving to the role of champion. In a few isolated cases, there is evidence of movement to the role of a coach.

The bureaucratic nature of the organization, clearly evident from the data, highlights the difficulty both organizations had in moving from siloed thinking to a more systemic and holistic view of the organization. While there appears to be some movement towards a system driven, and in some cases to a philosophy-driven approach, the high degree of instrumentalism means that the focus is on the deployment of tools. While the tools are more sophisticated and are helpful to a system view (for example Hoshin Kanri), the principles and philosophy behind the tools are not

understood or explained by organizational members within the governance structure of the project. Moreover, the principles and philosophy are not being seen in management practices.

The analysis thus far illustrates that the desired practices (presented in Table 11), expressing the principles and philosophy of lean, are unfortunately not evident in the organization. The organization continues to look for the 'one best way' that will allow them to successfully move to the philosophy driven level of transformation and a change in organizational practices, instead of questioning the values and beliefs of key organizational leaders.

Mackenzie and Hall (2015) indicate that getting to the philosophy-driven level of transformation requires organizational learning, which is particularly difficult for the organizations in this study. The adjustments made in the deployment based on the learnings of the action cycles illustrates first order learning; behavioural adaptation. Second level learning, defined as questioning the mindset, making explicit the values and assumptions at play and discussing the meaning of certain organizational elements was not apparent. It is a classic example of Argyris and Schon's (1978) Mode 1 of learning; responding to errors by recreating the conditions that led to those errors, instead of looking to new perspectives and thinking.

The analysis of the research cycles illustrates the difficulty the organization has in learning. There are several recurring preoccupations that are voiced by managers that may be seen throughout the narrative. Concerns of managers voiced at the managerial forum within the CHUS at the kick-off meeting for SPCHUS are echoed in the management forums at the CIUSSS de l'Estrie—CHUS in the fall of 2015. When the concerns are fed back to senior leaders in the organization, there is a tendency to justify the results instead of trying to understand what may be learned from the feedback. In addition, it appears that open and transparent discussion is problematic. On many occasions during the biweekly facilitation of the strategic Obeya, issues were

not addressed but tabled for discussion at a future meeting of the EMC behind closed doors. As one director, mentions, there is a certain level of discomfort in discussing performance issues openly:

> Moi je pense qu'il y a encore des tabous que les hors cadres ne veulent pas toucher pour toutes sortes de bonnes et de mauvaises raisons ; qui fait que la discussion des fois t'as l'impression que c'est un huis clos. C'est un peu particulier. C'est normal qu'il y en est, mais pour piloter la performance je ne vois pas, mais je comprends qu'il y ait des huis clos pour des décisions stratégiques politiques organisationnelles où qu'on ne va pas discuter dans une séance de pilotage, mais c'est comme s'il y a beaucoup de... je ne le sais pas, je ne sais pas ce qui se passe là, mais c'est ce que ça donne, l'impression qu'il y a un contre-message tu sais[cviii].

These examples, as well as others that may be found in the narrative and discussed previously in the analysis, indicate that control is a strong governing value in the organization, as is the case in bureaucratic organizations. Argyris (1997) indicates, "when controlling governing values are embedded in organizations, they constitute a nearly socially engineered impairment to learning. This impairment takes the form of organizational defensive routines that make problems undiscussable, and therefore, perpetuate it." (p. 303). Clegg *et al.* (2005) corroborate this, indicating that where there is no decentralized power, organizational learning is impossible. A lack of organizational learning is key to the analysis of a lean transformation from a cultural perspective and will be discussed more thoroughly in the following section.

4. ANALYSIS OF THE CHANGE PROCESS AS CULTURE CHANGE

The analysis of the action research cycles presented in Section 3 add to the understanding of the process of introducing an integrated lean management system in a healthcare establishment. This, in and of itself, provides rich insight and learnings for the organization which, if integrated into the next cycles of action, will allow them to progress towards their objectives of transformation. The objective of this research, however, was to illustrate, ***from a cultural perspective***, how a healthcare organization implements an integrated management system. The analysis of the implementation process with a cultural lens provides a more global analysis of the change, and

illustrates how actions are influenced by the meanings generated in interaction between the organizational members and various organizational artifacts.

As you will recall from Chapter 2, the definition of organizational culture, adopted in this study is based on the view that an organization 'is' a culture (as opposed to having a culture), and contains the following conceptual assumptions: organizational culture is dynamic and created through interaction; it is not cohesive—individuals create systems of meanings and symbols which are not necessarily shared by all members of the organization; and meanings and symbols are the most significant manifestations of organizational culture. In other words, culture is a process that is continuously practised and enacted (Khademian, 2010).

The dynamic cultural model of Hatch (1993) emphasizes the way in which cultural forms are created and used by organizational members. The interpretation, or meaning, given to certain symbols in an organization by its members leads them to act in certain ways. Significant in the learnings from the two action cycles are the differences in understanding of the meaning of several organizational elements, most importantly, the meaning of an integrated management system. It is evident that the actions of leaders and organizational members were different, based on the belief that a lean management system was tool driven, system driven, or philosophy driven. This difference in the interpretation led to actions that were perceived as incoherent by those that held the differing views.

If we look closely at the dynamic model of culture, we see that the interpretation of organizational symbols is influenced by our assumptions, these assumptions are then manifested in our personal value hierarchy, and these values are realized in organizational artifacts (Hatch, 1993). To illustrate this process, we will examine three

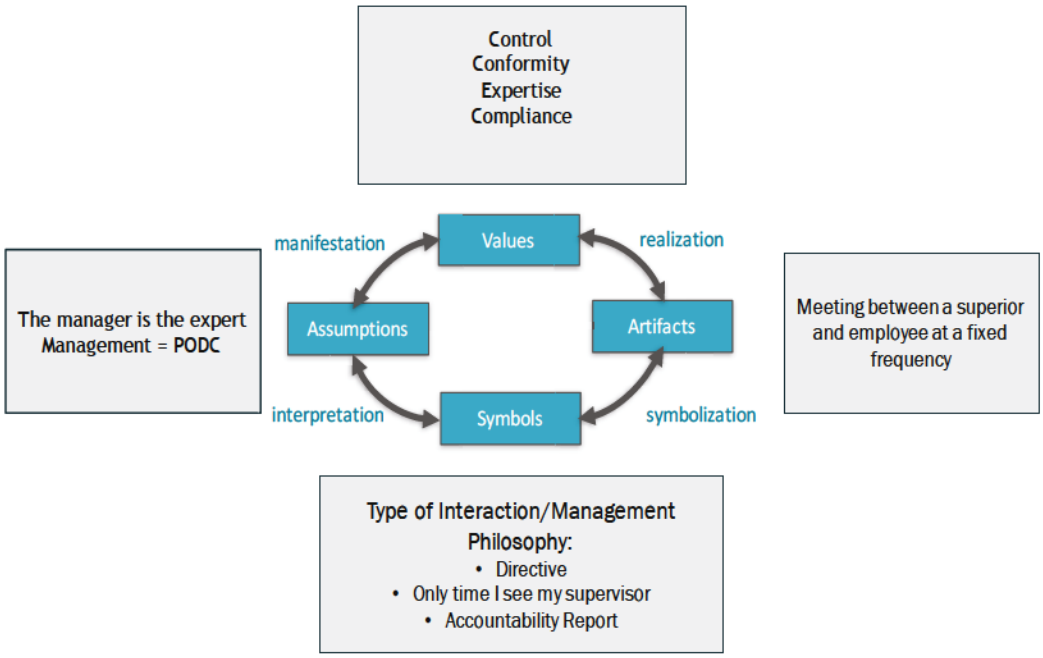
artifacts in the organization; the statutory meeting, the annual strategic planning process, and the Obeya[71].

These illustrations are based on an analysis of the responses to questions concerning these artifacts posed during the final interviews and on field observations by the researcher (as representations emerge through interactions they, therefore, can be studied through observation of day-to-day interactions [Allard-Poesi, 1998]).

The statutory meeting is commonplace in the public sector; it is a meeting between a hierarchal superior and their employee at a fixed interval in time. In a traditional management style, this meeting is meant to follow up on projects and basically ensure that the employee is completing the tasks expected of him/her. It is a meeting that is required by organizational norms. The meeting agenda for these statutory meetings was described by research participants as a 'grocery list' of items to be discussed since this was often the only time employees interacted with their superiors. The way the meetings were conducted provides evidence that the superior was thought to be an expert, and that their role was to plan, organize, direct and control in a very traditional sense. The values that manifest these assumptions most likely include control, conformity, expertise, and respect of commitments. And coming full circle in the dynamic view, these values then lead to the need for a statutory meeting whereby the employee is monitored, and the supervisor offers their expert advice when obstacles are encountered. Figure 28 illustrates this process.

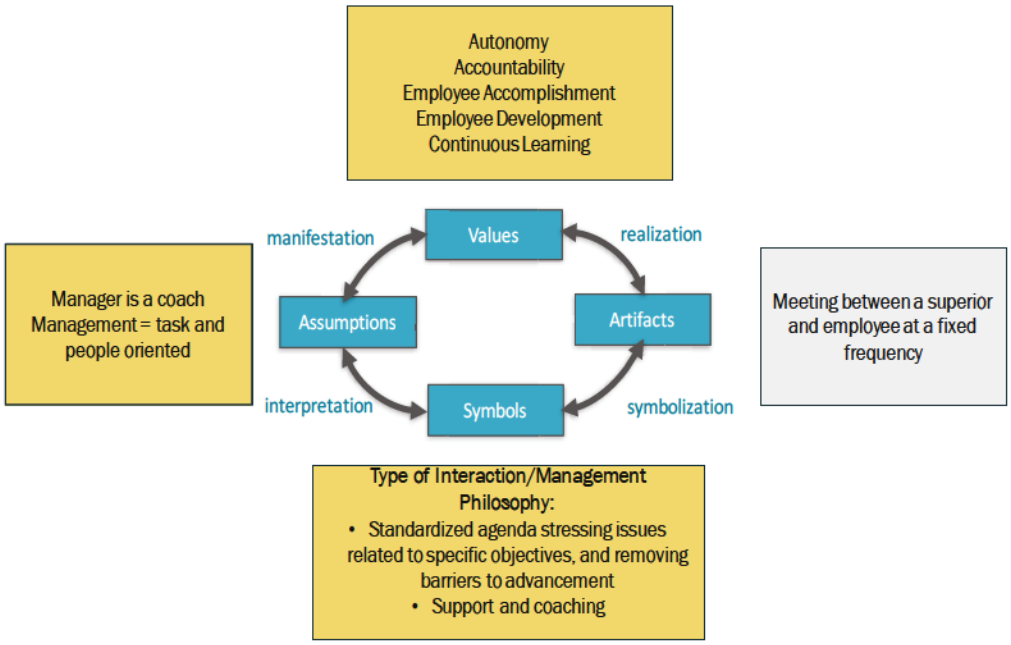
[71] Observations concerning the interaction among organizational members and between members and artifacts were observed over the three-year period of the study. Only three examples are presented to illustrate the dynamic process of culture. They were chosen based on their significance in the introduction of the management system.

Figure 28
Statutory Meetings: Illustration of the Dynamic View of Culture



If the organization had reached the philosophy-driven level of transformation, we would expect to see the dynamic cycle as illustrated in Figure 29. The role of leadership would be one of coach and facilitator. Beliefs regarding human agency and respect for people would manifest as values concerning human accomplishment, autonomy, development and continuous learning. The statutory meeting (a meeting at a fixed time and frequency) would remain as an artifact, but the meeting would be conducted differently. One would expect that the meeting would no longer be held in the superior's office, but in the workplace of the subordinate. Visual indicators would be present, and discussions would centre around difficulties and obstacles, and how the superior may help in removing them. The superior would also concentrate not on providing the answer, but on observing with the subordinate the workplace and developing the subordinate's skills in problem solving. The subordinate, experiencing this type of interaction would then question the underlying assumption that the manager is an expert, and this assumption would likely evolve to one where a manager is a coach.

Figure 29
Statutory Meetings: Illustration of the Dynamic View at a Philosophy Driven Level of Transformation



As the deployment of the integrated management system advanced in the second action research cycle, in some areas of the organization changes were observed in how the statutory meetings were conducted. The agenda for the meetings was no longer a grocery list of items but was focused around progress towards meeting the organizational strategic objectives. The supervisor/manager was perceived, by research participants interviewed, to be transitioning from providing solutions to coaching the individuals on how they may resolve problems using a standard problem-solving technique; and when difficulties were encountered the focus of the manager was to help remove these obstacles. The role of the hierarchal superior, in some cases, was beginning to be interpreted differently.

The following illustration makes evident this dynamic process using the annual planning exercise as an example. Figures 30 and 31 illustrate the original dynamic cultural process and the dynamic process at a philosophy driven level of transformation respectively.

Figure 30
Planning Process

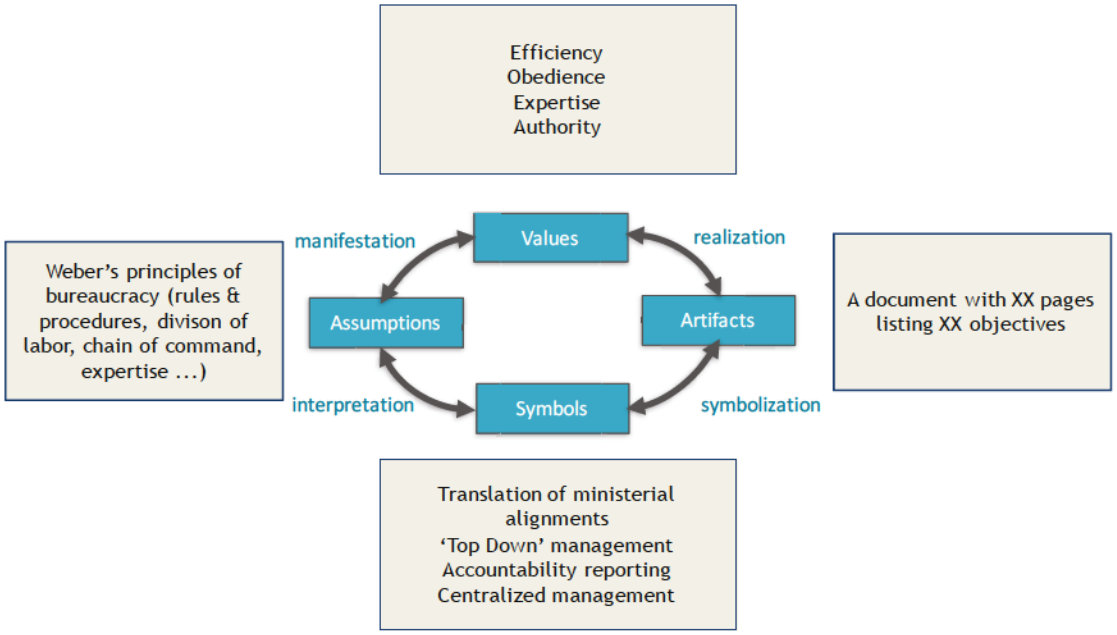
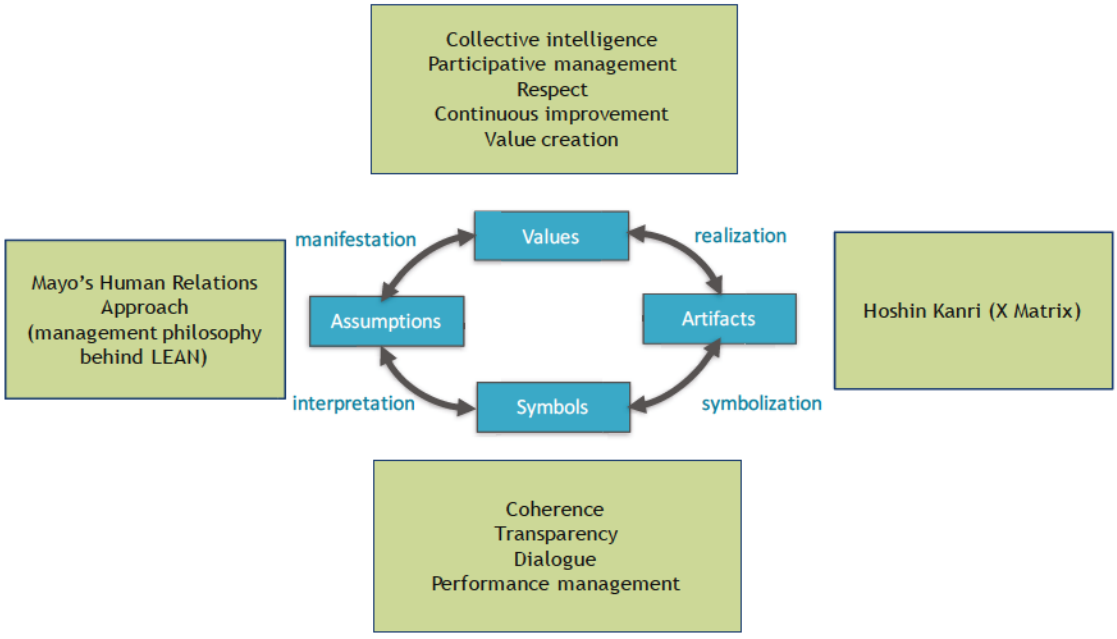


Figure 31
Strategic Planning at a Philosophy Driven Level



The original strategic plan for the CIUSSS de l'Estrie—CHUS, was created by a few individuals, and consisted of a rather long document integrating the ministerial objectives, and the priorities that had been identified by executive management. The plan was presented and approved by the Board, prior to presenting and discussing within the organization. This process exemplifies a rational and formal model of management. Organizational members, as they interact with the executive managers and the strategic plan, interpret the strategic planning process as top down and autocratic, with decision-making centralized at the top of the organization.

An organization that reaches the philosophy driven level of lean transformation, views the organization as a human system rather than a technical system. In a human system, respect for people is a fundamental value. Developing employees and creating a learning organization is of utmost importance. The process of determining the priorities is open and transparent and decisions are made through consensus (where consensus does not mean everyone is in agreement, but that there is an opportunity for dialogue and that all voices are respectfully heard). At this level, performance indicators are clear, and priorities are identified based on the critical areas requiring improvement. Interaction with senior managers, and with the artifact itself, lead to interpretations of the strategic planning process as transparent, as fact-based (and not anecdotal) and participative.

Following the creation of the initial strategic plan presented to the Board in the spring of 2016, the organization undertook a Hoshin Kanri exercise with several of the senior directors, in order to focus the organization on the critical priorities. This was identified as a critical event in the implementation of an integrated management system. For the first time, an extended group of directors focused on determining the priorities for the coming year. The format of the plan (the artifact) was different; instead of a long multi-page document, the strategic plan was contained in one 11x17 sheet of paper and tied to improving performance of the True North indicators. For those directors involved in the process, the strategic planning process began to be interpreted

as a more collaborative and transparent exercise. Some dialogue was evident; however, several discussions were tabled for a later date among the executive managers. In addition, some of the priorities were changed following the Hoshin Kanri exercise, without the presence of those originally involved. This leads the researcher to conclude that classical principles of bureaucracy may still be seen manifested in values of control and efficiency.

For those senior directors that did not participate in the exercise, communication of the priorities and the presentation of the strategic plan, in the Hoshin Kanri format, was not interpreted any differently from the previous form of the strategic plan. Their lack of involvement, and lack of discussion in the establishment of the organizational priorities, reinforced their view that despite the change in form, the process was still autocratic and top down. Again, changes in interpretations are seen in only isolated areas within the organization.

A final example of the dynamic process of culture is the strategic Obeya. As described previously a strategic Obeya is not simply a tool facilitating coherence of action and performance improvement but is thought to be a system whereby visual management and employee involvement are key. The documents posted in the Obeya are intended to represent the current performance, strategic challenges, organizational priorities, and key projects. Animation of the Obeya at a philosophy-driven level of transformation is focused on supporting daily operations (and not on simply reporting results), leading senior managers to reflect on their role in supporting employees in removing roadblocks to improved performance.

Figures 32 and 33 illustrate the facilitation of the strategic Obeya using the dynamic model of culture.

Figure 32
Strategic Obeya Illustration

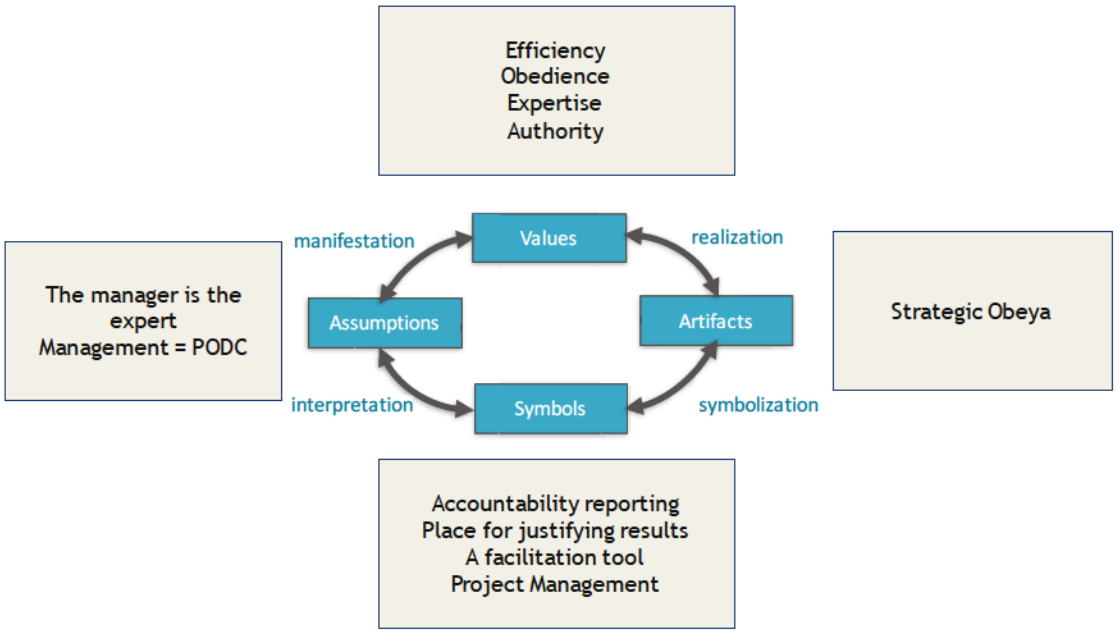
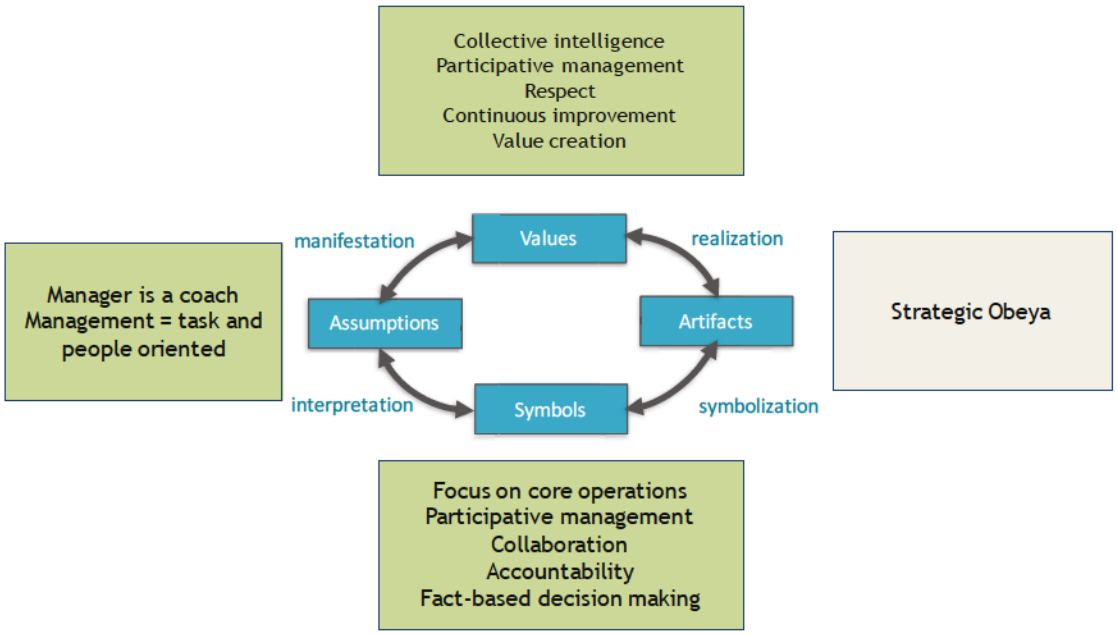


Figure 33
Strategic Obeya at a Philosophy Driven Level of Transformation



As mentioned in the narrative, animation of the strategic Obeya was scheduled on a by-weekly basis and was frequently cancelled due to conflict with other organizational priorities. As seen in the previously, the organization had difficulty with identifying and measuring key performance metrics, discussing performance openly and transparently, and focusing on operational performance instead of on progress of various projects. It is perceived that the Obeya remains a tool that was implemented to satisfy the requirements of the Ministry. The previous two figures illustrate that the current interpretations of this symbol are reinforcing assumptions of classical management.

The intention of the implementation of both SPCHUS and SGIP was to achieve a philosophy driven level of transformation. The assumptions and values of the management philosophy behind the desired management system are very different than those that existed in both healthcare establishments. Analyzing three specific artifacts through the lens of the dynamic culture model, it is noted that to achieve this level of transformation requires a fundamental change in symbols and meanings. In other words, the implementation of an integrated management system, inspired by a lean philosophy, requires culture change. As illustrated in the examples above, this level of transformation did not occur, except in a few, very isolated areas of the organization.

The meaning given to symbols is based on our basic beliefs and assumptions; if meanings are not evolving then it follows that the interactions are not leading to questioning these beliefs. For those participants for whom interpretations changed concerning the role of a leader, concerning performance management, or concerning the role of front-line workers, underlying assumptions were questioned and modified. In many cases, however, changes may be seen in organizational artifacts (such as with Hoshin Kanri, and the Obeya), yet the assumptions of ‘classical’ or ‘traditional’ management theories (i.e. Fayol, Weber, Taylor, Smith) and values are reinforced in daily interactions.

The questioning of basic beliefs and assumptions is the central element of second order learning. Mackenzie and Hall (2015) indicate that moving to the philosophy driven level of lean transformation requires organizational learning; and Cook and Yanow (1993) indicate that second order organizational learning may be considered as cultural change.

The results and analysis suggest that the introduction of an integrated management system, inspired by a lean philosophy (considered a philosophy-driven level of lean transformation) does require culture change; it demands modifications in organizational meanings that occur through organizational learning. A tool-driven or system-driven implementation of lean will provide some improvements but will not bring about the kind of transformation described by both the CHUS and the CIUSSS de l'Estrie-CHUS in the vision for SPCHUS and SGIP.

This conclusion, and the description of how culture change occurs using Hatch's (1993) dynamic model of culture, provides valuable insight for the organization on the approach to change. It has been documented frequently that planned approaches to changes rarely succeed. Alvesson and Svengingsson (2008) have previously highlighted that the high failure rate may be explained by a lack of consideration of what is going on at the individual level in terms of interaction and the inter-subjective creation of meaning. Planned change may be thought of as a relay race where the responsibility of deployment is passed from one level to the other in the organization. Senior leaders are responsible for conceiving of the changes to be implemented and lower-level managers are responsible for executing. A metaphor of a 'football game', suggested by Alvesson and Sveningsson (2008), is more appropriate for change, as it illustrates the required involvement and engagement of all players throughout the change program, rather than the handoff of a relay race. The necessity of frequent huddles in this metaphor is an important part of a view of change as more emergent than planned. Frequent opportunities for interaction and dialogue are essential if a culture change is desired.

Providing a space for reflecting on underlying beliefs and values, in other words, providing space for learning that leads to modifications in meanings is fundamental to the success of a lean transformation (cultural change). Leaders have a significant role in culture change, but in a manner that is very different than the conceptualization of this role in the variable perspective of culture. If, as in this study, an organization is conceptualized as a culture, and we define culture as a 'loosely structured and incompletely shared system of symbols and meanings', then it follows that leadership may be defined as the 'management of meaning' (Smircich and Morgan, 1982). From this perspective, leaders have a distinctive opportunity to influence the sense-making of others. They need to tend to others interpretive schemas on the basis of which people interpret their interactions and embody in these interactions the meanings that will lead to desired organizational actions (Sackmann, 1990). This requires questioning one's own assumptions and values, without this, the existing culture is reinforced despite changes in the 'tools' being used.

This view of leadership and management promotes the idea of management as a holistic and systemic discipline, requiring different skills than traditional management, and emphasizes organizational learning. It's important to note here that the researcher is not suggesting an intense philosophical discussion of beliefs and convictions, but more a discussion on how, in daily interactions and activities, the actions taken reflect the underlying principles of the change desired. The examples of several situations provide practical examples of how interactions among organizational members and between members and the artifacts introduced or modified with the implementation of an integrated management system may be influenced by leaders through a modification of the understanding of the role of leadership.

The results of the analysis of the implementation of an integrated management system, based on a lean philosophy were presented to the Executive Management

Committee (the steering team for SGIP) in April, and to the Tactical Committee at the end of June 2017. The reaction of both groups to the analysis is presented next.

5. REACTION OF THE ORGANIZATION TO THE FINAL PRESENTATION OF THE RESEARCH FINDINGS

On April 13th, the research results were presented to the Executive Committee of the CIUSSS de l'Estrie — CHUS. The time allotted for the presentation and discussion originally was one and a half hours. Two days prior to the presentation this was reduced to 45 minutes. Finally, the presentation and discussion lasted one hour and eleven minutes. The meeting was recorded, allowing for a verbatim transcription and analysis following the meeting. On June 29th, the results were presented to the tactical committee. Again, the meeting was recorded, transcribed, and analyzed. Prior to presenting analysis of the reaction of the research participants, the agenda for the meeting, and a summary of the key results will first be discussed.

The presentation began with a review of the conceptual framework of the study (the managerial problem, theoretical constructs that informed the research, and the operational framework). A summary of the critical events of the first and second cycles of the action research was then provided, along with the key learnings generated by the research participants at the end of each cycle, and the adjustments that were made based on these learnings. The key elements influencing the introduction of an integrated management system were then explained. These elements, discussed in detail in section 2.1, are summarized below:

A. The difference in meaning of an integrated performance management system for various organizational members leading to various actions that were misunderstood.
B. A high degree of instrumentalism in the introduction (tool driven, emphasis on conceptualization, search for the 'one best way', and the perceived positioning of executive directors outside of the change).
C. The bureaucratic nature of the organization (division of labour [both horizontally and vertically], the separation of conceptualization and execution, a strict chain of command [top down versus bottom up]).

Analyzing the implementation, based on the levels of transformation introduced by MacKenzie and Hall (2015), was next discussed. While the intention of the transformation within both organizations was a fundamental change in 'how things are done', the change that actually occurred may be situated somewhere between a tool-driven and system-driven level of transformation. The necessity for organizational learning to get to a philosophy-driven level of transformation, which was the intention of SGIP was discussed, and the analysis demonstrating the lack of organizational learning was presented.

The analysis of the change from a cultural perspective, linking organizational learning to cultural evolution was then explained. Evidence of basic assumptions viewing an organization as a rational system was presented, and the changes in meaning of various symbols and artifacts that one would expect to see when an organization is viewed as a human system was discussed. The important role of leaders in managing meanings, and the necessity to allow time for reflection was also highlighted.

Following the presentation, the four executive directors indicated that the description of events, and the analysis and results reflected their experience. Nonetheless, they made some suggestions in terms of nuancing areas of the analysis and the results. First, it was felt to be important to emphasize that in terms of division of labour, the fact that discussions and decisions were made only among the executive management committee was a result of efforts to improve collaboration among the Executive directors, to learn to understand respective points of view, and to present a united front in terms of the positioning and vision of the most senior leaders in the organization. The executive committee reminded the researcher that following the reform and creation of the CIUSSS de l'Estrie—CHUS, the executive management team was composed of 8 people (the four executive directors, and the directors of the DRHCAJ, DRFL and the DQÉPÉ). It was only in January of 2016 that this structure was modified to permit the four executive directors to develop as a team and to fulfill

their role in providing the vision and direction of the organization. This perspective is summarized by one of the Executive Directors:

> Je pense qu'il y a un élément quand même assez important qui n'est pas mentionné dans ton analyse et qui peut-être, existe, mais que je ne vois pas. […] Dans ce qu'on a tenté de faire puis manifestement pas avec un immense succès de quatre hors cadres à tenter de diriger une organisation, il y a des éléments dans ça qui doivent être nuancés par rapport à la réalité d'avoir quatre dirigeants dans une organisation. […] Quand tu parles de strate, quand tu parles d'étanchéité, quand tu parles de ces éléments-là il y a des façons de faire qu'on a peut-être utilisées ou il y a du positionnement qu'on a utilisé qui n'était pas un seul dans une tête. On était plusieurs qui devaient prendre une décision et qui devaient se concerter et qui devaient apprendre à se concerter aussi. On s'est donné un prérequis qui n'apparaît pas et c'est d'être le plus monolithique possible. Et, tu sais, cette discussion-là quand quelqu'un vient présenter ici, cette discussion-là qu'on veut avoir à quatre, c'est pour préserver ou avoir une image relativement monolithique de comment la direction générale va se positionner. Donc, d'ouvrir la réflexion, la discussion, avec trois ou quatre autres personnes pour quatre personnes qui ont à apprendre à travailler ensemble puis à vivre ensemble, à se tolérer ; faire ça avec des invités ce n'est pas toujours simple non plus[cix].

Second, the group felt that the presentation would be richer if there were more accent on the complexity of the context. The perception of a lack of vision of organizational members is explained as being a result of the fact that while they were concentrating on determining the organizational structure and filling the management positions within that structure, they were also becoming familiar with their new positions and roles, figuring out what the vision meant for the organization, and responding to the requirements of the ministry (that were being issued at breakneck speed). The committee explained that they had come a long way in a short amount of time, particularly given that discussions concerning the integrated management system among the original 8-person executive committee only began in March 2016.

> C'est que moi j'ai l'impression qu'on a joué un jeu d'échecs extrêmement complexe sur quatre paliers. C'est comme si ça, ça ne paraît pas. On a joué à un jeu dont on devait inventer les règles à mesure qu'on jouait le jeu. Alors il y avait, tu sais quand on dit que la vision ; on a vu à tel moment, la vision n'était pas très claire non

> plus. On la clarifiait à mesure. On inventait les mots à mesure qu'on voulait interagir avec les gens là. Ça, ce n'était pas évident. Il y a aussi toute la recherche d'équilibre individuel et d'équilibre de groupe dans cette démarche-là qui, à mon sens, a été un travail extrêmement considérable à faire ; où chacun d'entre nous — parce qu'on parle du replacement — chacun d'entre nous on a vécu le replacement. On le vivait tout en accompagnant quelqu'un qui devait le vivre aussi. Alors ça, pour moi, c'est des éléments qui viennent expliquer le tourbillon. Tu sais, qui vient teinter ce tourbillon-là[cx].

Third, it was difficult for the committee to understand that research participants perceived the executive directors as positioning themselves outside of the change. It was felt that the presentation of the results by the researcher only presented one side of the story, and that the executive committee members themselves were affected and involved in dramatic change as much as all other managers in the organization. It was not understood why this was not perceived by organizational members.

And finally, the Executive Directors indicated that individually they have often reflected on how they could have managed the implementation of the reform and the desired introduction of a lean management philosophy any differently. Specifically, the question they asked themselves was whether the present situation in the organization was normal, or could they have "scored" better or more rapidly.

What additional information does their reaction add to the present research study? For the researcher, it indicates several opportunities where the presentation of the results could have been clearer or framed differently in order to more precisely provide the importance of organizational learning to lean transformation (and culture change). Unfortunately, this was difficult to do with the time allotted. The lack of questions of clarification, and efforts to truly understand what the results meant to the organization, indicates a lack of desire, or an overwhelming lack of time, to understand what may be learned from the research, and how it may be applied to continue with the desired transformation. For the reflection stage of action research to work efficiently it is important that the participants be willing to take the steps necessary to incorporate

the insights into the planning of further actions; to take the time to ensure that no self-deception occurs (French, 2009).

It should be noted that the context of the reform was (and still is) extremely challenging for the organization and for all organizations in the healthcare sector. This was highlighted in the challenges at the end of the first action research cycle, and in the description of events of the second cycle. The results and analysis of the implementation of an integrated management system is in no way an evaluation of the competency of the senior level managers; they were placed in an impossible position with the introduction of the reform. The research study illustrates that lean transformation requires culture change and organizational learning plays a significant role. This simply means that the role of the manager becomes one of managing meaning that a metaphor of a football game is a more appropriate metaphor for managing change, and that periods of reflection in order to question and discuss basic assumptions are essential. The significant elements of the study are not the evaluation that was made in terms of implementation or in terms of a cultural change, but rather, based on the analysis, how the organization may continue with the implementation of an integrated management system to effectively transform the organization and ensure sustainable improvements in healthcare delivery as intended.

A presentation of the results to the tactical committee was scheduled for April 18, 2017. The meeting was cancelled, and the committee did not meet again until May 30, 2017, at which time the researcher was unavailable. The presentation finally occurred on June 29, 2017. The presentation and discussion lasted one hour and forty-two minutes, and as previously indicated was recorded and transcribed for analysis.

The Tactical Committee indicated that the description of events, and the analysis represented their experience. Understanding the transformation from a cultural perspective provided the research participants with an interesting perspective in which to understand what had occurred during the implementation, why the evolution of

culture was fragmented within the organization, and the role of, and the necessity for organizational learning if the implementation of lean principles is to be successful. Two of the research participants wondered if it was "normal" to be at this stage of evolution considering the context of the reform. It was mentioned that it was difficult to imagine how the implementation could have been conducted differently when an organization was in the process of being created from the merger of 15 different organizations, in a context of reduced funding. These participants indicated that the signs of change were encouraging, and that there was optimism that the change would continue to progress.

Other participants, however, indicated that they were not necessarily optimistic. The necessity to clarify the intention of the desired transformation was critical, and there did not appear to be signs that the Executive Management Committee (the steering team for SGIP) was committed to investing time to do this. There had not been a meeting with the steering committee to discuss progress on the deployment within the four pilots since January, nor had there been any facilitation of the strategic Obeya. The director of the DQÉPÉ mentioned that, following a recent discussion with the PDGA (the sponsor for SGIP), there would be changes once again to the governance structure for SGIP in the fall. For the researcher, this represents another manifestation of the difficulty the organization has in getting to second-level organizational learning; the organization is changing the governance structure because the current structure is not working (a change to what is being done) and not getting to the reasons why it may not be working. Several of the research participants mentioned their desire to spend time discussing the findings of the research with the Executive Management Committee to make the adjustments to the continued integration in the coming year.

Juxtaposing the reactions of the two committees provides interesting insight into the dynamic within the organization. At the tactical level, there is a conscious effort and a desire to move forward with the implementation to attain a philosophy-driven level of transformation. The committee members, having spent time integrating the various aspects of the management system and to understanding the results of the

research, have a more holistic and systemic view of the organization and the path to improvement. Unfortunately, the intention, or vision for the organization is not clear at a strategic level. The EMC appears to be satisfied with the progress towards a system-driven level. It is unclear from the actions taken since January 2017, their intention in terms of future steps in the implementation of an integrated management system.

CHAPTER FIVE
DISCUSSION

This chapter discusses the theoretical and practical implications of the research study. It begins by returning to the original research question, rooted in a specific managerial problem faced by the healthcare establishments under study. In a review of the existing literature on concepts related to the managerial problem, several gaps were noted in the scientific literature, which will be reiterated here as an introduction to the contribution of the present study to the body of knowledge on lean transformations and organizational culture. The practical contribution of the research will then be considered from the point of view of the organization and participants of the research. The transferability of the research will then be discussed, and finally, the limits of the research will be presented, along with suggestions for future research.

1. THEORETICAL AND PRACTICAL IMPLICATIONS OF THE RESEARCH

1.1. Original Research Question

At the origin of this research is an organization desiring a 'profound transformation' in the 'way things are done' in order to substantially improve the delivery of healthcare. Improving quality, safety, efficiency and efficacy of public healthcare systems is a challenge faced across the world. Among the management practices adopted by the public sector to aid in this quest are lean principles. Success rates of lean implementations, as seen in Chapter 2, are extremely low. While organizational culture is often cited as a key barrier or a critical element to consider, the relationship between lean implementation and organizational culture is not often explored. The objective of my doctoral research was to illustrate, from a cultural perspective, how a healthcare organization implements an integrated management system.

1.2. Gaps in the Scientific Literature

Chapter 2 resumed the literature on lean and how lean principles have been adopted in the healthcare sector, in addition to summarizing the literature on organizational culture, organizational change and organizational learning. Organizational culture is identified in much of the literature as a critical factor when transferring management practices from the private to the public sector. Toussaint, Billi, and Graban (2017) define lean as an "organizational culture" and an "integrated system", Snyder, Inglesson and Bäckström (2016) suggest that organizational culture should be included in any research methodology of a lean transformation, while Taher *et al.* (2016) indicate that managing the transition to such a culture is largely missing from the literature. This doctoral research study partly fills this gap by illustrating, from a cultural perspective, the implementation of a lean management system, an avenue of study that has been suggested would advance the sustainability of lean implementations in the public sector (Radnor and Osborne, 2013).

The processual three-year study presented here provides a unique opportunity to study, in real time, the process of implementation of an integrated management system inspired by a lean philosophy. As an active participant in the change, with access to the organizations under study over a long period of time, it was possible for the researcher to provide a rich and detailed account of the implementation from the perspective of participants. It was also possible to observe and discuss the evolution in symbols and meanings in order to study the implementation from a cultural perspective. This detailed examination of the organization and its characteristics allow the findings to transcend the specific context of the study, generating an understanding of more general phenomena that the findings represent. The specific contribution of this research to scientific knowledge, particularly at the intersection of lean implementation and organizational culture, is discussed in the following section.

1.3. Contribution of the Research to Scientific Knowledge

1.3.1. Lean implementations in public healthcare

This processual research study adds to the body of knowledge on lean implementations in public healthcare and responds to suggestions for further research into the dynamics of such implementations. The implementation of lean reported in the scientific literature proposes an understanding of lean as a methodology and focuses on the implementation of a series of tools that if applied, will lead to improved healthcare performance (Radnor *et al.*, 2012). This particular study sheds new light on how the understanding of lean influences its implementation, and clearly shows that a tool-based approach, or a system-based approach focusing only on systems level tools, limits the transformational capability of such an implementation.

Throughout the study and analysis, it was noted that lean was discussed within the organization as a project or an initiative, the elements of the integrated performance management system were introduced as tools and finding the 'one best way' appeared more important than continuous improvement. This lack of understanding of the foundational principles led to a view of lean as a panacea for all organizational ills, rather than as a means to enable organizational learning.

To implement a philosophy of lean requires a deeper level of understanding of the principles that then are integrated into an overall management system (Mackenzie and Hall, 2015). The discrepancy in understanding between the tactical teams responsible for the conception and deployment of both SPCHUS and SGIP, and the steering committees at the executive level of the organizations lead to major differences in the specific actions taken by organizational members throughout the deployment phases. By following the implementation in real time over such a long period, it was possible to link the understanding of lean to its implementation and to demonstrate how important the understanding of lean is to the sustainability of the implementation.

The current research also emphasizes that lean implementation is a transformational process requiring organizational level support and changes adding to the findings of previous research studies (Pearce and Pons, 2013; Yadav, 2017) and enriching the understanding of the dynamics of a lean transformation over time. This transformation, as noted by Toussaint *et al.* (2017) "isn't achieved through a few improvement initiatives but instead requires time to change behaviours and develop a lean culture. Organizations should not expect to get great results by copying parts of this holistic approach." (p. 2).

1.3.2. Organizational Change

Based on the classification of Demers (2007) of organizational change theories, the study provides a clear demonstration of organizational change from within highlighting the intrinsic, processual and dynamic nature of organizational change. While the change introduced by the CHUS and the CIUSSS de l'Estrie—CHUS was managed as an episodic or revolutionary type of change, initiated and planned by top management with the intention of moving the organization from one state to another, it is evident that any change detected during the study was a result of continuous change occurring in everyday decisions, actions and interactions.

As Langley and Denis (2006) demonstrate, this type of situated change is often neglected in research on organizational change. To truly understand the trajectory of planned change, a study such as this provides insight into how intended change may be intercepted and transformed into something very different than was intended. This was demonstrated clearly in the work of the SPCHUS Development and Planning Team. The intended change was for the team to implement Daily Continuous Improvement; however, the team considered their role to be the implementation of SPCHUS, which represented a management philosophy based on lean principles. As senior management commented during the interviews, given their very different interpretation, they did not understand how SPCHUS had become so much larger than what was originally intended.

The present study of a change process over time also allows a glimpse of change and continuity and how they co-exist in organizations (Pettigrew, Woodman and Cameron; 2001). It is concerned more with the spiral like, open-ended and dynamic qualities of change; in other words, it is interested in 'changing' rather than in 'change' (Weick and Quinn, 1999). The intervention theories associated with continuous change are markedly different than the n-step change management theories based on Lewin's change sequence of unfreeze, transition and refreeze. This study illustrates that this type of planned change is unsuccessful, and supports the change sequence of freeze, rebalance and unfreeze associated with continuous change (Weick and Quinn, 1999). Here freezing refers to understanding and making explicit the dynamics at play in the organization and rebalancing refers to the gradual reframing of everyday experiences (Alvesson, 2013). It is this gradual reframing that leads to unfreezing (changing of the organizational dynamics). From this perspective, and as illustrated in this study, change is not simple, manageable and organized, as much of the change management literature professes.

1.3.3. Organizational Culture and Organizational Learning

The research represents a cultural study from a postmodernist philosophical perspective intended to provide a rich and deep understanding of cultural processes. This is unlike much of research found in the scientific literature that represents a functionalist or managerialist perspective, concentrated on understanding the key manifestations of culture and how they reflect specific typologies. The use of Hatch's (1993) model allowed the researcher to illustrate the dynamics of these processes during the implementation of an integrated management system based on a lean philosophy. It supports the works of authors such as Alvesson (2013), Alvesson and Svengingsson (2008), Meyerson and Martin (1987) who indicate that culture is dynamic and emergent, and less controllable by management than indicated by proponents of the variable view of culture.

The research study also provides further understanding of the importance of interaction and dialogue in cultural change work, building on the findings of Denis and Langley (2002). The importance of dialogue has been identified as "central to a model of organizational transformation." (Schein, 1993, p. 27). The present research study clairifies with precise examples the ways in which daily interactions and dialogue contribute to the evolution or reinforcement existing meanings. Meanings evolve only if the interactions lead people to questioning previously held convictions and beliefs.

This particular finding also sheds some new light on culture change as a dynamic learning process. Several authors (Cook and Yanow, 1993; Gagliardi, 1986; Yanow, 2000) discuss culture change in terms of organizational learning. The present study highlights that cultural change is only beginning in areas where higher level learning is occurring. In addition, the literature on organizational learning is dominated by unitary views (Easterby-Smith *et al.*; 2000). The learning in the cultural processes studied in this research, however, contributes to the perspective that learning is fragmented, as is organizational culture. Furthermore, the research emphasizes that change does not imply learning, as Fiol and Lyles (1985) have argued.

As seen in Chapter 2, Gagliardi (1986) distinguishes between apparent cultural change (a change in behaviours), cultural revolution (new values and assumptions, antagonistic with the present culture, usually introduced by a new organizational leader) and incremental cultural change (the insertion of new values and assumptions that occurs through organizational learning). The present study is an example of apparent cultural change, whereby only behavioural change occurred. Lozeau *et al.* (2002) would call this co-optation or corruption of a management technique; the techniques of implementation allow for the reproduction of existing roles and assumptions.

For incremental culture change (the only type of culture change which is viable according to Gagliardi [1986]), second order learning must occur, and as seen in this

research, for this to occur it must be possible to raise and discuss the underlying assumptions and values. As many authors suggest, it is precisely this dynamic capacity for learning that is central to a lean philosophy (Aij, Visse and Widdershoven, 2015; Ballé, Chaize and Jones, 2015; Emiliani, 2003; Holweg, 2007; Pearce and Pons, 2013; Tsasis and Bruce-Barrett, 2008). And, when control is a fundamental value, learning is extremely difficult, leading to the question of whether or not a lean transformation is possible in the organization.

1.3.4. Lean Implementation and Culture Change

The most significant contribution of the study is to the body of knowledge at the intersection of lean and organizational culture. The research illustrates that the implementation of an integrated management system, based on a lean philosophy requires culture change, and reinforces suggestions that cultural analysis provides a much deeper understanding of how and why lean transformations succeed or fail (Davies and Mannion, 2013; Snyder *et al.*, 2016).

The scientific literature enumerates various barriers and facilitators to lean implementation in healthcare, as demonstrated in the summary presented in Table 2 of Chapter 2. A more recent publication by McLean, Antony and Dahlgaard (2017) suggests that failed implementations may be attributed to too much bureaucracy, organizational complexity, hierarchal management structures, a lack of openness to change, ceremonial adoption and closed vertical communication. This doctoral research highlights all of these elements as present in the organization under study, and furthermore, the results suggest that barriers identified in the literature are in fact manifestations of the underlying assumptions that are predominant in public healthcare.

As Emiliani (2003) suggests, and as illustrated in this study, the beliefs of traditional management practices and the beliefs of lean management are very different. In studying a lean transformation in the healthcare sector using Hatch's (1993) dynamic model of culture, the influence of these underlying beliefs on the

values manifested, and on the interpretation of organizational symbols is highlighted and the underlying beliefs associated with each type of management are presented. The study also provides a rich description of a lean implementation with extremely modest results which may be explained by a lack of development of new beliefs, reinforcing the findings of Emiliani and Stec (2005). An extremely important facilitating factor for sustainable lean implementations, then is the ability of the organization to make these underlying assumptions explicit and discussable, and if required, changed in order to realize the intention of the transformation. In other words, a lean transformation requires a cultural change, and hence, the main challenge is to facilitate organizational learning which is necessary for this cultural change to occur.

1.3.5. A Leader's Role in Lean Transformation

The previous theoretical contributions enumerated are all focused on a processual and dynamic view of an organization, where interactions and dialogue are at the centre of organizational changes. Based on the results of this study a lean transformation requires a cultural change, whereby interaction and dialogue allow for reinterpretations of organizational phenomenon, for the generation of new meanings and, hence, for a change in underlying assumptions. Leading a lean transformation, therefore, becomes a question of leading cultural change and many leaders fail to understand what it takes to do this (Snyder *et al.*, 2016). The present study provides a rich description of how leaders actions influence organizational culture through their everyday actions and interactions, adding to the body of literature of a leader's role in culture change.

As previously mentioned in the analysis of the change process from a cultural perspective, leadership in cultural change may be thought of as the 'management of meaning.' The role of the leader in implementing this type of change, from a processual and dynamic view of the organization, is quite different from the prominent view in the scientific literature. From the findings of this research, cultural change requires organizational learning. Leadership in a lean transformation then becomes one of

facilitating a change in understandings. This builds upon the works of authors such as Langstrand and Elg (2012) and Aij *et al.* (2015), which indicate that the main challenge in lean transformations is altering mindsets.

Meeting this challenge involves self-development on the part of leaders; the "capacity to maintain awareness of one's own behaviour, thinking, feelings and to consciously choose how to present oneself to others" (Aij and Teunissen, 2017, p. 721) is critical to the success of this type of change. A leader's understanding of their own tacitly held beliefs and assumptions, allows a leader to determine how they may modify their interactions in order to embody the beliefs and assumptions that underlie a lean management system (role modelling). By doing this, and encouraging dialogue and experiential learning, a leader facilitates cultural change (Hendry, 1996). Unfortunately, as seen in this study and documented in the literature, when change is managed top down, learning is mostly absent (*Idem*, 1996).

In summary, a leader's role in a lean transformation becomes one of redirecting continuous change in the desired direction. As a lean transformation requires culture change, the study supports the finding of Emiliani (2003) that the way it is implemented must reflect a desire to learn.

1.4. Practical Implication of the Research

This study is rooted in an approach to social research that engages the scientific community and practitioners to co-produce knowledge that addresses both a specific managerial problem while at the same time advancing scientific knowledge (Van de Ven, 2007). The action research methodology, more specifically action learning, facilitated group reflection and understanding of the meaning of certain situations providing a basis for planning. These were carried out in a "more systematic manner that what usually occurs in daily practice" (French, 2009, p. 195).

This methodology, therefore, allowed for periods of analysis and reflection throughout the study that were uncommon in the organization. The portrait of the change efforts provided by the researcher proved useful to participants in understanding what was occurring and the changes that may be required in order to meet their objectives. The following comments, recorded during the final interviews, reflect the perception of the participants on the practical contribution of the research:

> La réflexion que tu nous aides à faire par rapport aux apprentissages qu'est-ce qui va ; qu'est-ce qui ne va pas ; où est-ce qu'on est rendu, moi je trouve que c'est une mine d'or qu'on a pour la poursuite, parce que ça nous force à prendre du recul. Ça nous force à prendre du recul et c'est des moments clés où est-ce que là on va aller chercher le pouls d'un paquet de monde[cxi]. (Manager)

> Les gens qui ont justement la tête dans le déploiement du système lui-même, ils n'ont pas forcément le réflexe de reculer pour voir comment ajuster la manière. Puis, donc, les boucles d'apprentissage qu'on pouvait vivre, ça a clairement permis d'ajuster une position de tire. Donc ça, moi je pense que c'est super sain. Au niveau tactique ça a résonné beaucoup[cxii]. (Professional)

> Moi, j'ai remarqué que tu nous as ramenés ; tu nous as fait souvent un reflet ; tu nous as souvent amenés à nous poser les bonnes questions. […] Fait que je dirais que oui, c'est certain qu'il y a une valeur ajoutée. Est-ce que ça aurait pu être davantage ? Très certainement. Ça, c'est notre volonté à nous comme organisation[cxiii]. (Manager)

> Tu sais, tes questions sont toujours songées, réfléchies puis pleines de sens ; puis amène les gens à dire « on est-tu sur la traque ou on n'est-tu en train de dérailler. » Je pense que pour moi ça a aidé beaucoup. On serait perdu ; on se serait perdu à plusieurs reprises sans ta recherche puis sans tes interventions[cxiv]. (Director)

> La recherche-action est venue aider à mieux nous recentrer puis à nous donner une possibilité de rétablir nos priorités aussi[cxv]. (Executive Director)

The continuous reflection provided by the researcher allowed the organization to learn from the change process and continue on the path of their lean transformation. The introduction of Mackenzie and Hall's (2015) levels of transformation, allowed the

organization to situate their desired transformation, and to understand their progress. By highlighting the different meanings that the integrated management system holds for various members, it will be possible for the organization to initiate the appropriate discussions to determine the next steps and perhaps provide a framework for attaining their vision of the desired change.

The identification of elements that contribute to a lack of second—order learning, essential in the desired culture change, also has practical implications in the organization. In other words, the study made explicit what was implicit in their practice (Robinson, 2001), and how they themselves have contributed to maintaining the status quo. Demonstrating through very specific examples that control is highly valued in the organization, and how this prevents the organization from learning, will perhaps provide the organization some insight into how this may be overcome.

While the potential of the findings of this research to help the organization meet the intention of the implementation of an integrated management system is great, in practice, their impact will most likely be limited. In order to get to the intended philosophy driven level of lean transformation, organizational learning is required. And, as noted by Davies and Mannion, 2013, "real change requires detailed and sustained work on the ground" (p. 3). It requires champions of the change that demonstrate commitment to the change, and passion and persistence, in not only promoting and communicating but also embodying the change in daily interactions that are required for changes in meanings that lead to organizational learning (Hendy and Barlow, 2012). While these types of champions exist at the tactical level of the organization, there is some question as to whether these champions exist at the most senior levels, and whether organizational learning is a priority.

> Le plus beau projet de recherche de rétroaction peut ne pas donner rien à l'organisation si l'organisation n'est pas en mesure de l'utiliser pour les bonnes raisons, tu sais. Puis au fur et à mesure[cxvi]. (Senior Manager)

> Les plateformes de recherche actuellement pour l'ensemble des activités, je ne pense pas qu'on a réussi à l'animer puis le coordonner correctement à date. Je dirais c'est un effet neutre pour l'instant. Je pense quand même qu'il y a beaucoup de potentiel, soit dit en passant. Puis je sens que ce potentiel-là arrive. J'ai hâte de voir si on va être capable de l'actualiser par exemple[cxvii]. (Executive Director)

The reception of the results of the research by the Steering Team (EMC) and the Tactical Committee is extremely telling. Following the presentation, several organizational members (an executive director, and several senior managers) reached out to the researcher for a better understanding of the results, indicating an interest in adjusting the deployment based on the findings. Neither the executive sponsor nor the A3 owner for SGIP demonstrated interest in exploring the results further.

The practical applications of this research apply not only to the research participants of the organization, but also to the research practice of the researcher. It was mentioned in Chapter 3 that the positionality of the researcher shifted from an outsider in collaboration with insiders to an outsider within. The mode of learning was one of co-learning, however, as evidenced by the comments of organizational participants below, my positioning may have been perceived as that of a consultant, hired to facilitate the transformation for the organization (and will be discussed further in the limitations).

> Parce que t'as joué plus qu'un rôle de recherche. À mon avis, t'as joué presque un rôle d'accompagnateur. Ok, moi c'est ce que je pense. C'est l'impression que j'ai. Peut-être tu vas me dire « non, non c'est mon rôle », mais moi je pense que t'as joué un double-rôle. T'as été pratiquement comme si t'avais été un consultant qui avait été embauché par le CIUSSS pour venir aider[cxviii]. (Manager)

> Je pense que s'il n'y avait pas eu la recherche-action, si tu n'avais pas été là avec ton regard externe, ton miroir hebdomadaire quotidien ; puis l'objectivation puis forcer le questionnement, il n'y en aurait même pas de tentative de déploiement de système de gestion[cxix]. (Director)

The researcher learned from this the importance of adequately clarifying her role in the organization not only at the beginning of the research, but continuously throughout the research. Also, important for the researcher was a more practical understanding of the difference between action learning and action science, which will be helpful in future research using an action research methodology.

2. TRANSFERABILITY

This research studies the implementation of an integrated management system, based on a lean philosophy, over a three-year period in an organization in the healthcare sector. The results may not be transferable to all situations of the implementation of lean, however, the rich detail of the context and the change process should allow other establishments to evaluate the ways in which this particular example may be similar to theirs, and to use the learnings for the implementation of a management system based on lean principles within their organization.

In more general terms, the details provided on the dynamic process of implementation may also be relevant for organizations in general wishing to instigate organizational changes that involve a change in beliefs and assumptions.

Given that the organizations under study, the CHUS and the CIUSSS de l'Estrie - CHUS were seen as a model organizations in terms of their advancements with lean methodologies, in addition to being lauded by the Health Minister as being one of the best managed integrated health centres in the province[72], the learnings are of particular interest in informing the MHSS on the implementation of the current reform. The MHSS has indicated that the intention of the reform implemented in April 2015 was to fundamentally change healthcare delivery in Quebec to substantially improve quality, safety and efficacy, and have themselves described this change as a cultural change.

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[72] Source : La Tribune, 26 janvier 2018 « CIUSSS : l'Estrie a fait ses devoirs » https://www.latribune.ca/actualites/estrie-et-regions/ciusss--lestrie-a-fait-ses-devoirs-f7c00c53b136726d2661c3d922406faa

The essence of the implementation is, however, structural. This type of reform in public healthcare has been used across the globe to improve healthcare; unfortunately, studies have found that structural reforms alone are not extremely effective. In addition, top down reorganizations of public healthcare have been shown to produce effects that are contrary to the aspired objectives (Ovseiko and Buchanan, 2012). In the two-year longitudinal study by Cloutier *et al.* (2015) documenting the reform initiative of 2005 in Quebec, the authors concluded that despite enormous efforts, the reform ideas inevitably confronted the existing ideology of the healthcare establishments, and the desired radical transformation never materialized. For structural reforms to be effective in improving healthcare performance, they must occur alongside cultural change (Allaire and Firsirotu, 1985; Looi *et al.*, 2016; Parmelli *et al.*, 2011). And, as this study has suggested, cultural change requires organizational learning. Even in one of the best managed organizations in the healthcare sector, organizational learning is very difficult due to several characteristics that were highlighted in the study. Many will likely recognize these characteristics in their own organizations as they are characteristic of public healthcare organizations in general (Mackenzie & Hall, 2015).

In transferring the results of this study to the healthcare sector in Quebec, indicates that it would be interesting for the MHSS to reflect on the manner in which the reform has been implemented, to question whether or not actions taken are reinforcing the elements they wish to change with the reform, and to ponder if there is adequate dialogue and interaction that would lead to questioning the underlying assumptions and facilitate organizational learning necessary to achieve the culture change desired. Otherwise, the intentions of the current reform, as with previous structural reforms, will not materialize.

3. LIMITATIONS

The specific tactics used in the present study to counter potential limitations were enumerated in Chapter 3. Despite the efforts to counter these, some limitations may remain. We feel it necessary to discuss these here.

While the study conducted over the three-year period provides a rich description of the process of implementation of an integrated management system and contributed to knowledge concerning a lean transformation and cultural change, it remains a single case study, whereby the individual participants played a large role. A similar study with different participants would have most likely led to different results. This does not, however, mean that the findings are any less interesting. Given that the organization desired cultural change, had chosen the implementation of a lean management system as a mean to transformation, and were open to participating in action research study to learn, this case study richly illustrates that even under favourable conditions cultural processes are complex and dynamic and based on interaction that are difficult to change.

The context of reform meant that the research participants were involved in all kinds of activities that turned their attention away from the transformation that was desired through the implementation of a lean management system. As this study illustrates, the implementation of a lean management system requires culture change; in other words, it requires changes to meanings which happen through interaction. This requires time, persistence and a clear understanding of the current underlying assumptions and the changes that are required. The reform implemented in April 2015 had potential to facilitate this, as it basically exploded the healthcare network as it was previously known, and allowed for the possibility of a new configuration, not only of the structure but of the underlying assumptions. Unfortunately, with the guidelines for changes that were imposed by the MHSS, the focus was on meeting the deadlines for implementation. Probably the greatest impact of this was on the ability of the organization to learn. “In learning terms, too many activities dissipate energy and

attention, and prevent reinforcement of any learning. There is no closure to the experiential learning cycle, allowing concrete experience, reflection, consolidation of principles, and further testing and improvement." (Hendry, 1996, p. 631).

It was also extremely difficult for the organization to adopt management practices based on a very different ideology than traditional management practices with the MHSS continuously reinforcing the postulates of traditional management with the implementation of the reform. While this limited the progress of cultural change within the CIUSSS de l'Estrie—CHUS, it did highlight the contrast between the two ideologies, and how an important difference in understanding of the ideology impacts the evolution of culture. However, these elements do not lessen the contribution of the study and may in fact strengthen the findings on the importance of learning for the cultural change inherent in the implementation of an integrated management system based on a lean philosophy.

It is also apparent that as a single researcher it was not possible to follow and observe all of the organizational activity hroughout the research period. In particular, it was not possible for the researcher to observe interactions of the Steering Team when it became the EMC at the CIUSSS de l'Estrie— CHUS. Nevertheless, individual interviews with the members of the EMC and observations of the meetings where they were involved provided enough material to analyze the implementation and cultural processes from various different perspectives.

As a doctoral student and researcher, I did not necessarily have the credibility or authority to incite the senior executives to reflect in more detail on their underlying beliefs and assumptions. It was noted by participants that despite this, several observations and feedback provided during the study did allow for some reflection on the part of senior executives. As mentioned previously, questioning of a tacitly held mindset requires a willingness to learn. The lack of questioning of underlying beliefs and assumptions may be more related to an unwillingness to learn than to the credibility

of the researcher. In either case, the success or failure of implementation was not the principal objective of the study. Understanding and illustrating the implementation process was, and despite a lack of learning, the research provides a deeper understanding of some of the cultural processes at work.

Despite the limitations identified, the validation of the narrative by participants, the group discussions concerning learnings, the use of field journals and memos to trace the evolution of understanding of the processes, the researcher believes that the study contributes to the literature at the intersection of lean transformations and organizational culture, providing a deeper understanding of the dynamics of this type of change, and also opens new avenues for research.

4. SUGGESTIONS FOR FUTURE RESEARCH

The lack of research at the intersection of lean transformations and organizational culture is notable. The present study, conducted over a three-year period is one of a very few that attempt to bridge that gap. The researcher would encourage others to continue studies in this area, with particular attention to following the cultural process of change using the dynamic model of Hatch (1993).

The present study examined in detail the dynamic processes of organizational culture during the implementation of a lean management system. The data collected also raises questions concerning the political processes and/or the institutional processes at work. It would be interesting to reexamine the body of research material from these perspectives in the future.

The methodology of the research relied mainly on action learning. The adjustments made to the implementation of an integrated management system were adaptive changes in what was being done. The results of the study underscore that a lean transformation requires a culture change, and, therefore, beliefs and assumptions must be questioned. Working with the senior leaders at the CIUSSS de l'Estrie-CHUS,

the results of the study could be used to make explicit the underlying assumptions that are preventing organizational learning and ultimately preventing the desired transformation. Action science would be well suited to this and would be an interesting avenue of future research not only at the CIUSSS de l'Estrie-CHUS; but at other healthcare establishments wishing to continue along a path of lean transformation to a philosophy-driven level.

CONCLUSION

At the heart of this research study is a public healthcare organization implementing an integrated performance management system in order to fundamentally change the 'way things are done'. The organization had reached the limit of what their current practices could offer in terms of improvements. An integrated management system based on lean principles offered a distinctive perspective where the underlying assumptions were very different. The public sector has been trying to adopt management principles from the private sector in an attempt to improve efficiency, emphasize accountability, decentralize decision-making and streamline processes for many years. Lean is the most popular of the practices that have been subject to transfer to the public sector, and the healthcare sector is not an exception.

Several theoretical constructs were investigated in order to provide some insight into the managerial problem. The overview of lean provided in this research argues that a lean philosophy reaches beyond the methodology and is expressed through management practices and reflected in a management system. A lean management system is based on two fundamental pillars: respect for people and continuous improvement. At the heart of such a system is a dynamic learning capacity. The approach to successful implementations of such a system, noted in the literature, is similar: patient well-being is critical, supporting the people who work in hospitals is essential and sustainable long-term change that is broad and deep is the only answer. The barriers to successful implementation, however, are numerous.

Organizational culture is frequently identified as critical to consider in lean transformations; however, researchers rarely operationalize the concept. Culture is complex, messy, and difficult to understand (Alvesson and Svengingsson, 2008). It is a dynamic process that is continuously practiced and enacted. The processual perspective of this study rethinks culture, thought to be a fairly stable phenomenon, as

dynamic and constantly changing. It blurs the distinction between the symbolic and cognitive theories of culture, as Lakomoski (2001) and Hatch (1993) do, believing that human cognition, considered to be the property of the individual mind is not radically separated from its external symbolic representation. It also demonstrates the importance of social interaction and dialogue to the evolution of organizational culture and the significant role of organizational learning in this process.

The implementation process of a lean management philosophy remains a key and under-investigated issue in the scientific literature (D'Andreamatteo, Ianni, Lega and Sargiacomo, 2015) and several authors have suggested a cultural analysis would provide a much deeper understanding of how and why lean transformations may succeed or fail (i.e. Davies and Mannion, 2013; Snyder *et al.*, 2016). Based on the managerial problem faced by the two public healthcare organizations of this study, and the lack of answers in the scientific literature, this doctoral research illustrated how the implementation of an integrated management system, based on a Lean philosophy requires culture change.

The methodology of action research was particularly well suited to investigate this question, as it mirrors the intention of a lean transformation to introduce a dynamic learning capacity in the organization. Two action research cycles were completed, covering the period from January 2014 to 2017. Notable during the period of the research was the introduction of a major reform on April 1, 2015, reorganizing the 182 public healthcare establishments and the 18 Regional Health Agencies into 34 Integrated Centers of Health and Social Services.

The qualification of progress following the first action cycle at the CHUS was somewhat disappointing to research participants. While considerable progress was made in the intellectual understanding of SPCHUS, there was little evidence that this understanding had been translated to action. The key learnings from this cycle included the recognition of differing interpretations of SPCHUS at the tactical and strategic

levels of the organization, the necessity for the implication of senior managers in the deployment, the importance of integrating the concepts into an overall system and ensuring that interim objectives were defined as milestones to the attainment of the vision. Based on the learnings several suggestions were made to continue with the deployment of an integrated management system at the newly formed CIUSSS de l'Estrie — CHUS.

The second research cycle was characterized by an enormous amount of activity to integrate the Regional Health Agency and the fourteen establishments within the Eastern Townships into one integrated healthcare establishment. The learnings from this cycle were organized around the work of Karen Martin, described in her book *The Outstanding Organization,* which had captured the imagination of the CIUSSS de l'Estrie — CHUS. The importance of clarity, focus and discipline in the implementation was noted by the research participants in the learnings. A lack of clarity was noted in the communications concerning SGIP, in the roles and responsibilities of the various instances in the governance structure of the organization, and in the lack of clear indicators of performance. All of these contributed to incoherence in actions taken to deploy SGIP, wasted time in clarifying information and redoing work in addition to impacting the quality of decision-making. A lack of focus and discipline was noted by research participants in the difficulty to determine the critical few priorities and follow them through until improvement was noted. Based on these learnings, suggestions for adjustments to the deployment were provided and implemented by the EMC.

Over the two action cycles, evolution in understanding of the meaning of an integrated management system based on a lean philosophy may be noted. As the analysis showed, lean means a lot of different things to a lot of different people involved in the implementation. The study demonstrated that the understanding of lean greatly influenced the actions taken during the implementation. Three very distinct understandings were evident. At the very beginning of the study, prior to the development of SPCHUS, Lean was perceived by many organizational members as

Kaizen. This is evident in the discourse of several organizational members, discussing SPCHUS as something more than Lean. This evolved to an understanding of Lean as a Daily Management System (Continuous Improvement) during the course of the implementation of SPCHUS, and at the beginning of the creation of the CIUSSS de l'Estrie — CHUS. In certain areas, the evolution continued with Lean being a set of principles embedded in a holistic and systemic Management System. Taher *et al.* (2016), describe the distinction between a Lean Daily Management System and a Lean Management System. While their study developed a framework for deploying an LDMS, the present study underscores the tension, ambiguity and confusion generated by the co-existence of these various interpretations of lean in an organization desiring a philosophy-driven level of transformation that relies on the implementation of a Lean Management System.

The various interpretations of the integrated management system being deployed, combined with a high degree of instrumentalism, and the bureaucratic nature of the organization noted over the two cycles, led to a perception of organizational members that there was a lack of vision, and a lack of coherence between the discourse and actions during the deployment. Given the action-oriented nature of the organization, the reason for implementing the system was never addressed, much less the implication of adopting lean principles to the organization. The group discussions concerning the vision for the management system from March to June 2016 at the CIUSSS de l'Estrie—CHUS were focused on identifying desired management practices, completing the Hoshin Kanri, and implementing a strategic Obeya according to the Ministry guidelines, not on why it may be necessary to change certain practices, and how this would be beneficial for the organization in making substantial improvements in the delivery of care. These findings emphasize that Lean is not a panacea; the tools and methodologies cannot solve all of the organizational difficulties. Of critical importance is not only understanding the underlying principles of Lean, but also understanding why an organization wishes to implement these principles.

In looking more closely at the adjustments that were made following the two action research cycles, it was noted that the only changes that were introduced were behavioural in nature. A questioning of the underlying beliefs and assumptions did not occur in either of the research cycles. Instrumentalism, the bureaucratic nature of the organization, and the difference in the understanding of an integrated management system noted over research cycles all contributed to a lack of second order organizational learning, which, as was seen, is critical to achieving a philosophy driven level of lean transformation.

Most of the scientific literature documenting lean implementations describes successful attempts at change. However, unsuccessful attempts, such as this one, provide rich insight into the dynamics of an implementation. First, the multiple cycles of planning, doing, reflecting and adjusting, and the evolving understandings of participants provided a comprehensive appreciation of the implementation of an integrated management system inspired by a lean philosophy. Application of the framework of lean transformations of Mackenzie and Hall (2015) made it possible to describe the intention of the implementation of the management systems of the organizations (system-driven for SPCHUS, and philosophy-driven for SGIP) and analyze the level of transformation achieved based on the triangulation of field observations, interviews and secondary document analysis. This type of in-depth processual study, providing a detailed description of how change is occurring over the iterative cycles of action research, is rare in the scientific literature on lean healthcare. The identification of the understanding of lean as a particularly important element in transformation was central to this study.

Second, this research provides insight into the cultural processes at work during a desired transformation, something that has been called for, but rarely (if at all) seen in the literature. Analyzing the transformation using Hatch's (1993) dynamic model of culture, it was possible to trace over time the evolution of (or reinforcement of) interpretations of organizational symbols. This model allowed insight into whether or

not the culture was evolving, and to identify key reasons why it may or may not have changed. The importance of dialogue has been identified as "central to a model of organizational transformation" (Schein, 1993, p. 27). The present research study, builds on this, and with precise examples indicates the ways in which daily interactions and dialogue contribute to the evolution or reinforcement existing meanings. Interpretations change or remain the same, based on whether or not the interactions lead people to questioning previously held convictions and beliefs.

The analysis then links this questioning and changing of a previously held mindset to second-order organizational learning providing a contribution to the understanding the role of organizational learning in culture change. While the cultural view of organizational learning has been previously explored (Cook and Yanow, 1993), this research study demonstrates how organizational learning contributes to changes in meanings that are essential to cultural change. Yanow (2000) indicated that the study conducted with Cook in 1993 unintentionally portrayed a unitary, integrationist view of culture. This study provides evidence that organizational learning is fragmented. All participants in the study were members of the same organization; the organizational leaders, organizational priorities, the healthcare environment, and desired change were the same for all participants. Yet, individual interpretations, based on interaction with superiors or subordinates, and with organizational artifacts, were very different. This supports the cultural view of learning, but clearly shows how this happens from a fragmented perspective of culture.

The third element highlighted in this study concerns the role of leaders in cultural change. Research on managing culture identifies leadership as the single most important factor in changing culture (Armenakis *et al.*, 2011; Ogbanna, 1992). This research study provides a better understanding of their role; instead of managing change from above, a leader's role becomes one of managing meaning and of facilitating organizational learning. For the desired transformation to be successful, managers need to invite input from others in discussions, ask probing questions,

encourage multiple points of view and provide opportunities for discussion and reflection. It also provides concrete ideas in terms of behaviours that would help in realizing the objectives of the lean implementations.

In summary, through active participation in the deployment of an integrated management system within a public healthcare establishment in Quebec, and the cycles of action, observation reflection and adjustment it was possible to follow the dynamic process of change and illustrate, through the use of Hatch's (1993) model of cultural processes that the implementation of an integrated management system based on a lean philosophy implies a change to meanings and, therefore, requires culture change. The change in meanings occurs through organizational learning. As Argyris (1997) indicates, and this study confirms, in bureaucratic organizations where control is a central value, organizational learning is next to impossible.

It would be fair to question the influence of the healthcare reform on the findings of this study. The CIUSSS de l'Estrie – CHUS is an impressive structure given the geographical territory it covers, its 100 points of service and its 17000 employees. It has been questioned whether managing an organization with the size and complexity of the CIUSSS de l'Estrie – CHUS is even possible[73]. The Executive Management team had an extremely daunting task in incorporating 14 establishments and the Regional Health Agency into one integrated health center. Most obviously, the sheer amplitude of the reform, and the requirements of the MHSS in the implementation left allowing for very few opportunities for reflection and learning. Nevertheless, there were pockets in the organization where lean principles were integrated in to daily activities and cultural evolution was apparent, emphasizing the importance of organizational learning to culture change, and clearly illustrating that the implementation of a lean management system requires culture change.

[73] Michel Magnan, specialist in Governance, University of Concordia, reported in La Tribune, 9 avril, 2018, p.2.

It is evident in this study the desire of organizational participants to improve the quality of the healthcare services provided. They are engaged and committed to finding new ways of organizing to ensure that service users, their families and the community are at the centre of the healthcare services provided. In order to unleash the potential of all organizational members to actually bring about the desired transformation, the organization needs to recognize the importance of, and facilitate, organizational learning. In order to this, senior leaders in public healthcare need to understand that "the past is alive in the present, and may shape the emerging future." (Pettigrew, 1997, p. 341). In other words, leaders themselves need to demonstrate an openness to question their underlying beliefs and assumptions, understand how these influence their day-to-day interactions and interpretations, and change these mindsets if they wish to shape a different future.

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APPENDIX A
TRANSLATION OF CITATIONS

i. Mission:
The CHUS team, by investing in teaching and research and in partnership with the community, provides high-quality care and services focused on the health needs of its population.
Values:
Respect—At CHUS, our interactions with others are based on both esteem and consideration. This respect is reflected every day in our words, behaviours, and actions.
Listening—At CHUS, we pay attention to people around us. We are available, empathetic, and open to others because we know that listening is the very foundation of all human relationships.
Team spirit—At CHUS, we combine our knowledge to achieve our common goal, which is to provide the best care and services possible. We need this mutual enrichment.
Professionalism—At CHUS, we carry out our work with proficiency, integrity, transparency, and rigour.
Creativity—At CHUS, we are open to exploring new avenues to meet everyday challenges while continuing to meet our patients' needs.
Vision:
Towards a better performing, more inspiring and human organization.

ii. And, in the last years, some data about quality was raising concerns for example, the 30-day mortality rates or re-hospitalizations, etc. Some sectors caused us great concern as did other aspects such as the deterioration in the work atmosphere and our ability to retain our professionals. Our retention rates for some professionals, including nurses, after 2 years was 60%. It was huge: 4 out of 10 were leaving. Clearly, a 60% retention rate is an enormous problem because you have to understand that we invest a great deal in new employees. So, this made us ask ourselves about the managers' role in supporting their team. How are they accompanying them? How are they supporting them? How effectively are they coaching them?

iii. Along the way, we also realized that in the GPS project we were being overwhelmed by a multitude of projects within the organization that, in the end, were never completed. So, people were distracted. Our managers were being scattered over several projects at once. They were not present in the care units nor in their non-clinical area. Projects were not moving forward. Based on this, we questioned how we could develop a performance management system that would address and resolve some of the issues mentioned.

iv. At the request of its Board of Directors, as early as 2009, the Centre hospitalier universitaire de Sherbrooke **was engaged in an in-depth transformation of its organization**. The GPS (Gestionnaire-Performance-Sens) project carried out over the last two years has allowed the CHUS to ensure a solid basis for this transformation to occur **which will have an impact on all levels of the**

CHUS' mission, its governance and structures, its approaches and management techniques, as well as on its culture and paradigms. This transformation conveys the renewed vision of a "more efficient and inspiring people-centred CHUS," which was introduced in the 2012–2015 strategic plan of the organization.

The main focus of this ongoing transformation is the trajectory of care for patients, being perceived as the locus where the experience of the patient and their close relatives is realized concretely during the medical care episode. **The trajectory of care is also seen as the area of interpretation**, of realization and evaluation of the organization's performance in producing the expected results for patients. Finally, the trajectory of care shall constitute the point where all efforts, based on a matrix model of management are integrated and will help the organization to **avoid a silo management model**.

This transformation shall fundamentally rely on the extensive deployment and on the intensive appropriation by all sectors of the **continuous improvement (LEAN)** as an operational management method inside its trajectories as well as in its contributing services. **With time, the outcome of this initiative shall be reflected in a new organizational culture** where front-line employees will play a key role within the new governance structure that will be put in place.

v. Transversally, with regard to the improvement of the trajectories of care for patients, I believe that we have not reached the trajectory level yet, but I feel it is necessary to do so. As shown in the last management tour, when front-line employees who tried to resolve problems raised their questions they then realized the impacts upstream and downstream of their process and the need to team up with other sectors. (Professional)

vi. Regarding continuous improvement, though I believe there is a greater awareness, I still think we are more in a project culture rather than in a continuous improvement culture. While I see some improvements, there is still room for more, especially in relation to the manager's role with front-line employees. What is their responsibility there? How do they see themselves as a manager? How do they see their responsibility regarding continuous improvement? I think that more needs to be done, but that's normal. (Manager)

vii. It's becoming less of a reflex to answer all questions with the same project management method: create a project, form a group, and proceed. It was the only solution. Now, I'd say the toolbox is getting larger because you get the feeling that you can talk to the director if you need to, and tell him what you need. People are able to find the necessary resources and solutions. We saw it with budgets when we had fiscal issues. Instead of investigating the matter, they were told when and where to cut. No, we need to look around, to go to see our people, and ask for suggestions. (Director)

viii. Many small islands of improvement, more and more, here and there, and, eventually, the islands will touch to create continents. This is my impression. Yet, communication is not good enough between the islands; we don't talk to each other enough, we don't know what others do yet. […] but I believe we are getting there.

ix. We invested a substantial amount of time in defining aspects of the SPCHUS. We tried to understand, to define what the SPCHUS was, what we were going to do, and how we were going to do it. We stayed within the parameters of concepts. We intellectualized. We remained theoretical. (Manager)

x. Most importantly, we succeeded in developing common vocabularies. We integrated the concepts. It took time. We had many discussions about that, but I think that we really went from conception to integration to implementation. (Director)

xi. With a certain synergy […], we started to have more than just a recipe, we had not just worked on a series of steps; we worked on different mindsets or mental models. But unfortunately, this was interrupted. (Manager)

xii. We can't say that it has not been initiated, but our leaders are no longer there to foster this kind of integration. (Manager)

xiii. Resources were allocated. […] SPCHUS is a hyper transversal project. Maybe our difficulties were as I said earlier—when you say: yes [this person is] an expert. They still have to take care of the accreditation. I mean, we have daily operations within our department even though we say we don't: we are mainly a service department, but still, we have objectives to achieve and, of course, it's the same for the person who is evaluating the patient experience. It has to be done and this isn't necessarily happening under the umbrella of SPCHUS. (Director)

xiv. In hindsight, I would say that the vision was not particularly clear. As far as I'm concerned, and because I have worked in the SPCHUS deployment, the purpose is still not clear. What is the purpose? What is the deliverable [outcome]? In that area, I'd say we are a bit off track. (Manager)

xv. The fact that we managed SPCHUS like a project […] it doesn't work in the sense that it takes years to deploy a culture, it's not something that has an end. (Professional)

xvi. We are aware that we treated it as a project. But it's not the kind of project where you'll find a starting and ending point. SPCHUS doesn't have a start or a completion. It's not as if you are installing an MRI where you do have a

beginning and dedicated resources and go for it. Because this is a change in culture, this requires integration. (Manager)

xvii. There is also the involvement of the hierarchal management structure which is necessary, fundamental, and must be transformed. (Manager)

xviii. … but their chief, their director, they are not there anymore and I lived it. [The hierarchical superiors] did not really inform them. It was not easy. (Manager)

xix. In retrospect, I'm wondering if it is a priority for the senior directors. It would have been beneficial to have another director to apply pressure for action, movement, integration, and to make it concrete. I think it would have been a good thing. (Manager)

xx. The most relevant players have not appropriated the vision; there is only one director that is actually supporting it. (Manager)

xxi. Just because we have the project SPCHUS, it does not mean we will stop evaluating patient experience. We have been doing it since 2008 and we will continue to do so. But how do we fit our functional goals into something more transversal? There's a key learning somewhere in there. (Director)

xxii. Because I'm involved with other director colleagues, I do see learnings in terms of the matrix management model. It would have been more difficult to get to where we are if the DISC, DRHE, and DQPEP didn't let go of certain elements of the current management culture. Before they were very decision-centred as in adopting a firm standpoint that a particular decision belonged to a particular department, and this other decision to that other department, etc. You see three columns. Of course, there is still a lot of work to be done here, around the table [with the development and planning team]—sharing of expertise, comprehension of expertise—but at the same time, it is important for the other level to begin to apply matrix management methods. I can't tell you everything that has gone on, but it is far from being simple. It is a learning experience which needs to continue.

xxiii. I'm hoping that the organization will make use of the learning experience gleaned from this intended transformation and at the same time, there is an opportunity to be grasped with Bill 10: a change in the structure that allows for management of trajectories, for teamwork and to involve managers in the trajectory and give up silo management by favouring more a more matrixed structure. (Professional)

xxiv. In hindsight, I would say that the vision was not that clear and neither was its purpose. And that, as far as I'm concerned and because I have worked in the SPCHUS, the deployment and the purpose are still not clear. What is the

purpose? What is the deliverable? On that subject, I'd say we are a bit off track. And still, we waste a lot of energy in trying to make it tangible, to be in action. (Manager)

xxv. Well, the demobilization of the teams with time required to align the various hierarchal levels. And also, there is a limit to the benefits of daily continuous improvement when it is only supported by front-line employees. It is erroneous to believe that changes are only required at this level. (Professional)

xxvi. Transform the managerial culture in order to create a learning organization capable of continuously improving the performance of patient trajectories. Within this organization, all members are mobilized and contribute to the best of their abilities to the improvement of the accessibility, quality and security of healthcare and services, while reducing operating cost through a judicious use of resources. The goal of the management system is to set guidelines for facilitating human interactions allowing team members move away from functional silos and to act daily on what is most important for the realization of the organization's mission. Interactions will be influenced by the identity and the organizational values and it is facilitated in action through coaching. Thus, co-managers are more likely to become coaches than experts and shall prioritize the development of their team's collective intelligence so that it may resolve increasingly complex issues.
The progress of transformation shall be controlled with periodic measures on managerial maturity according to the four dimensions listed below:
DIMENSIONS OF THE SYSTEM:
The *raison d'être* : To work with and for the patient and their family within the trajectories of healthcare and services.
The mechanics: To use strategy deployment to ensure that the strategic objectives are known throughout the entire organization.
The *savoir-être* : To develop co-management within a culture of transformational leadership.
The *savoir-faire*: To be equipped to continuously improve organizational processes.

xxvii. They need coaching; it's probably a symptom of another problem. The other problem is that they do not have the time to look at the internal organization and to pilot a change of this magnitude; they do not have the capacity. Knowing that; how do we resolve it? (Professional)

xxviii. I have been waiting for that. I needed to be attached to something bigger than our department.

xxix. Give us the framework and allow room for co-construction.

xxx. The framework will help us to stay focused and to let go of the unimportant projects.

xxxi. With the proposed approach, it feels like we are part of a much larger team. Before, we worked in isolation; now we are integrated into a system and we work together.

xxxii. Minimal because we took a step backwards. Essentially, we are fighting to get back to where we were. […] We are repeating the same steps but we are not getting any further. I did not dare to define a percentage, but in my opinion, it isn't more than 10%. […] We can tell that people look at us as if we are aliens when we talk about it. I imagine that it's the same for the people from other facilities who were managing performance some other way. They must feel the same way somehow. "Ah, you know, at the time, we used to do it this way and that way." That is why the culture has not evolved. I just think that we only took a step back, hopefully, it will lead us to be better, at least to unify us and to reach a level of standardization, harmonization of practices. (Senior Manager)

xxxiii. We are just starting. We are really only at the stage of an intention. (Senior Manager)

xxxiv. Last week, with the accreditation visit, we saw a lot of people are talking about the performance system, about the necessity for continuous improvement. Standardization. It is beginning to percolate, but we probably should be much further along after a year and a half; but we haven't gotten very far. We are only at the beginning, but it is a beginning nonetheless. (Manager)

xxxv. No. I believe that we are only repeating what the leaders did in their former organizations. I have heard this numerous times. Again, I'm not saying this pejoratively, but we are not changing a culture. We are just repeating a culture which already existed in some other places. (Senior manager)

xxxvi. The fact that they actually created an annual plan that they use for monitoring and the Obeya. The fact that they have cascaded the objectives in part. We'll see about the various departments. They conveyed this focus to each department. So, as far as I'm concerned, they are talking more about the content rather than about the container. This seems appropriate at this point in time. We have to experience it rather than asking people to imagine it. (Professional)

xxxvii. I think so. It represents a significant change in terms of there being a system for managing; which was not the case in certain other ex-establishments. (Director)

xxxviii. Before, we didn't have measurable targets for the annual plan. Now, we're halfway there. So, eventually, in the year following these learnings, we'll put less effort into the creation of the annual plan because there will be a part of it that will remain as is and only the balance will need to be updated. Consequently, a large portion of our energy will be used for improving the clarity of our goals so that our people can respond appropriately and can track their contribution. (Professional)

xxxix. I think that the organization is being sucked into a ton of actions that are required. The more mature the organization gets and the more stable the system gets, the more we realize that we will have to make room for planning and sharing knowledge in our agendas. We are getting there. (Executive Manager)

xl. It is more about shared decision-making and even more about transparency. It is less about finger pointing and more about identifying the issues and finding solutions. It is less about appearances and more about seriously looking at ourselves, even though it is still very difficult to do. (Director)

xli. The capacity of certain directions to initiate the analysis of a situation in order to find causes, not just within their department, but outside of the traditional silos and by calling on partners. This capacity is much larger than it used to be. We don't hear people passing the problem around as much. Instead, we see them being introspective, pulling together, and being aware of their own difficulties. These are all examples of cultural elements. (Director)

xlii. We are more focused on clinical operations. Let me be clear, we are not implementing operational processes. We are not regulating operational processes. It's more like, for instance, we know that we have an issue with the average length of stay in Granby, which is very high. An action plan is proposed and we ask questions such as: where are we on that? What does this information mean? We share information, find the right levers, and then we agree on the next steps together. We are strategically managing operations. It is less the politics of communicating the right things. (Director)

xliii. Certainly, at the executive management level, which is the first pilot direction among the other five; we can't visualize or put in practice the key behaviours, we have, how can I say it, generated more questions than answers. Another key action (which is incomplete if we look at the annual plan) would be to determine the key objectives. To clarify the gaol rather than imposing the means. (Professional)

xliv. The way in which they conduct the senior management meetings is getting us somewhere interesting. But there still is work to do on the manner in which the meetings are conducted at all other levels of the CIUSSS de l'Estrie— CHUS. We have had some good forums. It's interesting though; linking our vision of

our integrated performance management system with these meetings is still a challenge. (Professional)

xlv. At the steering committee level, yes; but now, when we get out of this committee, no. […] When we get out of the meeting, it feels as if it doesn't exist. But in the steering committee meeting, yes. So, I'd like to think that there is potential; but people don't see it. (Director)

xlvi. The progress is bipolar. There are some members of the organization who have been influenced. With the tactical committee for instance, it is the same thing as with our former conception group: we repeated the same case where we experiment, we tried to implement some tools, and we learn from the experience. This group has learned a lot. But that is not the most important part. We have not yet succeeded in bringing this learning process to the right level in the organization. (Professional)

xlvii. I'm disappointed that we can't translate it into action rather than just in the discourse. It requires having the courage of our ambitions. This means that if executive management wishes to implement an integrated performance management system with leaders that apply transformational leadership skills, they should know that currently many managers do not model transformational leadership behaviours. So, if they do want to implement that style of management—transformational leadership—there are two alternatives: we admit that there are managers that won't be able to adopt the desired behaviours and we get them out of the way or we invest time and energy in daily coaching that is not there at the moment. (Senior manager)

xlviii. What saddens me is that we couldn't find the common thread for the integrated management system. The model that became the system… I regret that we weren't able to come up with a proper progressive introduction strategy. Now we are stuck with demonstrating to all our managers that we are not adding another priority. It distresses me because we should have thought about it more and come up with a winning introduction strategy in the fall, even though we were restructuring. We should have found winning elements and then restructured them in relation to the trajectories; however, the trajectories are one of the elements. And despite the improvement of competencies, we couldn't find how to rally around an integrated performance management system and then a strategy. (Executive manager)

xlix. So, in June 2015, something happened. In September 2015, there was a new alignment because we had reflected more deeply. Later, there was yet another alignment and a lot of ensuing changes in the way the project was led. I think that those were the striking and difficult parts during that period. It was hard to tell who was leading what and it still is today. (Director)

l. Eighteen months ago, I thought that it would have been easier to draw inspiration from the best practices to the benefit of the population across the entire territory. I don't think we succeeded at all. Maybe it was because of the challenge of harmonizing or the challenge of restructuring the work teams. It remains a challenge. The good and best practices in certain areas cannot yet be brought to other areas without great difficulty. I would have thought that the fusion would have removed these obstacles away; but it is not so. (Executive manager)

li. I do think that the foundation of the system is one of….. it is an approach or a philosophy. It's a way of working that had the potential to colour all of our initiatives over the past year. But, in my opinion, we treated it as one project among 19. To create 19 priorities, 19 A3's in the spring 2015, was very different than saying that the system is our way of prioritizing and that the 18 others are filtered through the management system. The system is filtering, so we treated it as such. There probably was not enough time to discuss it in this way. (Senior manager)

lii. SGIP, I'm not sure that people understand the outcome of its implementation. I'm not sure that people understand the outcome; and that the outcome doesn't come at the end. It is omnipresent; it is in the way things are done every day. I'm not sure people understand it that way. (Director)

liii. Right now, people think the Obeya is [the integrated performance management system]. We have communicated it in this manner many times. We always give the Obeya as an example, as well as the visual workstations. It's simplistic, but we started with that vision. This is the focus and the tone we gave; therefore, it's normal that we now have to adjust. (Director)

liv. So, one of the lessons is that once we've decided about the management system elements, we have to implement it within the governing structure rather than implementing it in a parallel structure. (Senior manager)

lv. Sometimes, I feel like the executive management committee is working too much on elements that are not at a strategic level. When I think about examples of executive office responsibilities, I believe they should give advice how issues should be raised, how decisions should be made, but without adopting particular principles. This should be handled in other instances such as the senior management team or through the SGIP's larger steering committee. I find that they bring up far too many things are brought to the executive management committee. (Manager)

lvi. There are two separate things which have been mixed up. The roles are mixed up. The Tactical Committee is questioned about the management of regular operations despite its true role in working on the specific projects related to

this deployment. There are things that have been mixed up you know […]. We must clearly determine first what the permanent structure that supports a management system and then what the temporary structure that is there for deployment. (Executive Manager)

lvii. The governing committees for the management system need to be reviewed. For instance, it is difficult to differentiate the steering committee from the performance management committee. Their roles are being confused. I'm not so sure that the performance management committee is managing the affairs that it should. I believe that executive managers should be the ones managing the high level but instead they are caught up in "do you have the right form for managing appointments with specialized doctors." We are not all at the right level when we do this. (Executive Manager)

lviii. Accreditation. We used the same structure. The teams proposed a project structure—the Safe Delivery Committee and Ethical Code Committee. We did the same things with other projects, but there was a leader. There were project teams and it worked. Why is it not working out this time? I don't recognize myself in this. (Director)

lix. About selection for the pilots: there has been a choice for the pilots, but, given what was at stake, there was an aspect missing. Yes, they went through their annual planning process, but it was based on perceptions. I'm willing to believe that they are aware of their reality, but that is exactly what we want to change: instead of perceptions; go and observe in the field; collect data; and to see what is really impacting our performance. As a matter of fact, I believe it would've helped if we had based our choice of the pilot directions on this. (Professional)

lx. I believe that we still are scattered all over the place. We still have too many projects, too many ideas, too many objectives. In two months, it will be something else. Now, the ministry just announced supplementary budgets for home-support services, but it has not yet arrived. I believe that we are likely—I search for the right word—to be distracted by many different things. (Director)

lxi. To be willing to take a moment to ask ourselves, "What are we doing? What are the 2–3 things that really need to be changed?" instead of looking at all that needs to be done. What specific things, say, needs to be changed by Christmas? (Manager)

lxii. Some people might say that we have a big showcase, but no back store. Or, in other words, we sell a lot of things while our inventory is empty. (Executive manager)

lxiii. Our transformation is being influenced a lot by the ministerial guidelines mode: Check! Check! We are ticking off actions. It stops after the check mark; our bosses are very caught up in that. There is no box to check where we measure and verify the effect of the action. We are constantly in a reactive mode. (Senior Manager)

lxiv. We proceed with things we don't really understand. We move forward even though we are not ready. Also, we might be in a culture where everything needs to be done at once. It all comes down to going too fast, getting everything done and then thinking all is OK, that everything is perfect. (Senior Manager)

lxv. What is difficult when we start a project or when we make a decision is to anticipate the progression within the organization and to complete the loop as in the case with the A3 or the patient trajectories. We do part of it, but what comes next? It's as if the decision to do something is the entire loop, but when we decide to do "X", what do we do next? It's as if when we decide about something we are under the impression that it is done—short-term vision. We seem satisfied simply with the decision to do something. (Senior Manager)

lxvi. What do I have? I don't know. Maybe one day the literature will show it, but to implement a system with such a change in culture for everybody, in an environment of considerable transformation, takes a lot of audacity. I think we left wearing shorts and sandals, as someone I know well has said, when it was 20 below zero outside. And we thought that we would survive a long time, but I don't believe we were properly equipped. (Executive Manager)

lxvii. A lack of time, work overload, lack of recognition of senior managers by the Ministry of Health and Social Services and the population. You know, this perception ends up colouring an organization that does not have power over it. The size of the organization and the fact that it is multi-site combined with such a complete lack of recognition of this complexity by the Ministry who continues to say that there were no cuts in healthcare. (Director)

lxviii. The months are passing by and the comprehension of what is changing in the role is growing. The ability to assimilate change is highly variable—less than 50% will be able to integrate behavioural changes now. We are in a context of high control from above. It is easier to stay in a silo. It is so hard to manage my own silo and assume my new role. It is an ordeal to look outside of that. To date, all we have managed to do is observe, I steepest road climb in front of us has been there since last November. The clinical reorganization was done in February, barely six months since they put on their new shoes. The executive management is caught with a constant counter-example, and the weight of the counter-example and the willingness to change is shared inequitably by the 15 senior directors. Everybody has a different starting point in terms of their

comprehension. All these elements put together means we live through a lot of ups and downs. (Director)

lxix. Well, this tells me that the priority might not be to improve our ways of doing things. They are not ready to sacrifice time to get there. So, they keep answering external needs while not having anybody in a strategic position who is responsible for the internal efficiency of the organization. To me, they are more concentrated on responding—now that there is no regional agency—to external pressure. (Professional)

lxx. It requires what I called someone who takes on the pilgrim's staff, and who, on every occasion is coherent, is cohesive and who influences the people around them. I don't think we had such a person with at high enough strategic position to be able to influence the right level in order to open doors for the tactical committee, to clear the way. I think this is a problem. (Senior Manager)

lxxi. The SGIP governance structure has not been applied (experimented for two months only). The steering and tactical committees should be the time and place for discussion about the issues revolving around the deployment of SGIP versus the planning of the communications for forums, CCI, etc.;

lxxii. There is no clear leader for SGIP. Is the leader the executive management committee, the steering team or the SGIP sponsor. What issues should be addressed by the steering committee vs. by the executive management committee;

lxxiii. The roles of certain committees have not been applied. There is little room for neither for discussion concerning the interdependence between certain projects nor for escalating issues requiring resolution.

lxxiv. The executive of the tactical committee is non-existent.

lxxv. Is the governance structure in place adequate e.g. a project management logic for deploying SGIP?

lxxvi. What shall we deal with in project committees versus the organizational instances?

lxxvii. Which mechanisms should we formalize in order to deal with challenges in deployment?

lxxviii. How much time shall be invested in the meetings to discuss deployment issues (linked with the second role two of the steering committee)?

lxxix. How can we ensure that requests are addressed clearly, by the right person, to the right person or committee at the right time?

lxxx. What modalities are in place to migrate performance management to the interdirectional coordination committee?

lxxxi. No, no, no. It was taken for granted. Everybody knows what we are talking about. It's like for instance, the synchronized agenda: when we introduced the synchronized agenda people were wondering, "What it for? How is it going to help?" You know the meaning. There war some people trying to work on finding the meaning. I remember the first conference. On April 1, 2015, Ms. Gauthier conducted her first conference, which was very good. There was communication on that very first day with all managers. It was A+. But to see (I was at the institute) everybody's expression when she said: "Well, there—we just completed an A3 on this transformation." What? We are going to do our A3 and everything? Everybody at the conference was like "What is she talking about?" Nobody understood anything. It was understandable, since we came from 15 organizations and not everyone was familiar with an A3. There was problem solving, but not with the A3 mentality, which is very interesting, but we have to explain why we want to do it this way. We deployed things that did not make sense to people. (Manager)

lxxxii. Today, we are still at the point where we say "Let's deploy this" but we don't get the feeling that it is omnipresent and that it is part of a whole within our discussions and our decisions. (Director)

lxxxiii. We talked more about the project, but not about what we want to do with it. We talked a lot about A3's, but not about the priorities behind them. It's as though the means takes precedence over the meaning. (Senior Manager)

lxxxiv. We put a lot of value on the tools, but we do not discuss or value what we're trying to do with the tools. It is what the tools allow us to that is of importance in the transformation. (Manager)

lxxxv. The other key element was the annual strategic objectives. I believe it was an important element. Even though communication was exceedingly difficult, we did the work necessary. The communication was extremely deficient. (Executive Manager)

lxxxvi. That's what happened. We had to develop. We had to identify our ambitions. We had to identify values. We had to identify training. We had to identify skills. Unfortunately, it's catching up with us today because we didn't do it. And I continue to think that it's a shame. (Executive Manager)

lxxxvii. I would get rid of all the sophistication, of all the models and concepts as well as all the complex matters, spend more time in the field and in action. We spend

so much time discussing and creating all kinds of plans: a change management plan, plans for everything. It's incredible. (Senior Manager)

lxxxviii. It is impossible to transfer a conviction and an experience through words. It doesn't work. It has to be through action. (Manager)

lxxxix. We've reached the full capacity with what this structure could give us. I'm mainly talking about the steering committee and the tactical committee. We have difficulties with executing concepts. We can find all kinds of concepts, but can't seem to apply them. (Executive Manager)

xc. Since we remain in a project structure, there are very few people who are able to transfer the concepts into everyday reality. I believe this is where we are having the most difficulty. (Executive Manager)

xci. That we are having a hard time to make the system work; in terms of getting beyond explaining what it is. We have a hard time exemplifying it. It's as if we are unable to enter the "we'll do it, we'll live it" stage. (Senior Manager)

xcii. We need the Senior Management's and Executive Management's support, and this support can't be theoretical. We need practical support. (Executive Manager)

xciii. Well, if there is not a significant number of people who make the effort, we won't see any change. People look to us, and they imitate us. You can say that there is a management system, that we've set priorities and indicated that we will stop some projects but, if they don't see this, nothing will have changed. They have not seen us stop anything. Nothing has changed in our statutory meetings or management meetings. Well, we must … nothing has changed. (Manager)

xciv. I'd say that the Executive Office has not been able to modulate its processes according to management philosophy of SGIP yet. OK. Because of the way we manage the organization from the Executive Office, we were not able to get past that stage. How are we piloting our own priorities? We in the Executive Office how do we follow up on our indicators? What specific issues are we discussing? We have very strategic issues as well as very, very operational issues that should never get to the executive level. So, we stay caught in what we've always known and done. We did not succeed in getting past this stage. (Executive Manager)

xcv. So, if the very entity that is the Executive Office is not able to modify its practices accordingly, for sure the people in the field and elsewhere around us will feel it. You know, it is all very incoherent. (Executive Manager)

xcvi. Change must be carried out by all of us and it takes enormous efforts because you have to keep telling yourself, "You know, I could've fallen into the trap myself." I tell myself every day, "Wait a moment, you did this. What difference does it make today? Who will I see today? What do I have planned? So, I have a meeting next Thursday. Wait a minute… I cannot. —I have my first Board of Department Heads since I've done that. They don't necessarily know about it yet, but how could I prepare them for what I'm changing in my statutory meetings?" I'm always questioning myself about the changes I should be making in order to be coherent with our management system. All the time. (Director)

xcvii. Sometimes we can ask ourselves why it is they didn't do it. If we stop and think for a moment, we realize that it is often because *we* did not do it. So, you know, I can always ask them to collaborate, but I have to ask myself if I am in a collaborative mode with my colleagues. (Executive Manager)

xcviii. When we want to change part of a system or a system as a whole, we have to admit that we are part of that system. (Executive Manager)

xcix. And the other thing I'm learning as well is that when we want to change somebody, we have to accept that it will bring change within ourselves. (Executive Manager)

c. And, at the strategic level, the tendency is that we often follow the current trends. Even for [Mr. Someone], we will re-transform our way of talking via external sources. (Professional)

ci. When you are working in your department or function, then you are working within your management and have control over your resources, I believe that you are able to control this end. You are able to allocate the resources accordingly to your team and accordingly to the tactical objectives. But once it goes beyond the responsibility and accountability of my department, you can't find leverage… I believe that's where we are at. That is why it is difficult. (Manager)

cii. Now, we have an action-research project on collaboration. We can't even see what the links are to be with our system SGIP. They are still independent. It is not being worked on as if it were part of a management system. It is the same trap. It is not going well, and it still looks as though we are not proceeding in an integrated manner. (Manager)

ciii. You know, it's going from top down to bottom up. Our actions need to be coherent in order to get to bottom up. That is what was most incoherent in the last year. But at the same time, we gave ourselves a philosophy of management and that is what we wanted. And yet, that is not what we were doing, but we

were not doing it in the context of a major restructuration … but we did express this. We did not take the time to talk about it; maybe that is what we should've done. To integrate the model and to then say that is the model we are aiming for and we will get there progressively. If only we would have taken the time to explain this more. (Executive Manager)

civ. We reworked it again and again and again; but it was not easy. That's it. We are working backwards. How is it that as a department, as the DRH, that we should be supporting you? We will organize to provide the support needed. If you need guest speakers, we will find them for you, but you have to tell us what you want to say to your managers. They are your managers, not ours. What do you want to share with them? I find that the executive office doesn't take a leadership role in this. What the executive office does is micromanagement while not inspiring commitment, facilitating motivation, or providing an orientation or vision. They expect us to feed them. They criticize, they follow our ideas, and yet they are not sure. (Manager)

cv. We are under the impression that we should be the ones carrying the vision of the organization when it should be carried by the executive. (Manager)

cvi. We are not leading the organization. You see, the tactical committees work very hard but it seems many things end at this level. The EMC does not seem to look at what the tactical committee has done. They look to other sources, and then tell the tactical committee what to do. (Director)

cvii. It is symptomatic. But it wasn't seen that way. Then, it went well; which is a normal reflex for everybody. It always comes down to that when you are afraid of losing control: oops! You bring it back up. So that's what we did. (Director)

cviii. I believe that there are still taboos that the executive management doesn't want to address for all kinds of good and bad reasons and that makes it looks like the discussions happen behind closed doors. It is a bit peculiar. It's normal that it happens sometimes, but in order to pilot performance I don't see why it would. I understand the closed door context in making strategic political organizational management decisions where we wouldn't discuss it during a piloting meeting. Even though I'm not entirely sure about what happens in there, it gives the impression that there is a counter-message.

cix. I think that there is an important element that is not mentioned in your analysis or maybe it is and I don't see it. […] About what we attempted to do, which was obviously not a success for four executive managers in their attempt to lead an organization; there are elements that should be tempered by the reality of having four leaders within one organization. […] When you talk about strata, when you talk about compartmentalization and water tightness, when you talk about these elements there were approaches we might have used or a position we've taken that was not corresponding to one person only. We were

more than one who had to make decisions, who had to consult each other, and who had to learn how to do so. We've given ourselves a prerequisite that might not have been apparent, but it was about being as monolithic as possible. And you see, this discussion, when somebody comes here, this discussion that we want to have between the four of us is to preserve a relatively monolithic image of how the executive management will position itself. So, when you make the reflection process or the discussion open to three or four other people while mixing it with the other four who are still learning how to work and to live together, to tolerate, it is not easy. To do that with other participants is not easy at all.

cx. I feel as if we played an extremely complex chess game on four different levels yet it doesn't seem so. We played a game where we had to make up the rules as we were playing. Also, we realized that the vision was not that clear, so we were clarifying it along the way. We were inventing words as we progressed and as we wanted to interact with other people. It was not easy. There was also the whole idea of individual balance and group balance to be considered during the process, which was, in my opinion, an extremely important task to be done, where each of us—because we are talking about relocation—had experienced relocation. So, we were experiencing it while, at the same time, accompanying someone that was also living through it. So, in my terms, these are elements that can help explain the whirlwind nature of the activities. You know that colours this whirlwind.

cxi. The reflection process that you guided us through in relation to our learnings—what works, what doesn't; where are we at—I find it to be a gold mine that helps us to keep going in our deployment because it forces us to step back and reflect. These are key moments that will allow us to feel the pulse of a lot of different people. (Manager)

cxii. The people who do have their heads deep into the deployment of the system as a whole don't necessarily have the reflex of stepping back and seeing how to adjust. The learning loops that we have experienced clearly help in adjusting our position. That is very healthy, in my opinion. At a tactical level, it did resonate a lot. (Professional)

cxiii. I did notice that you brought us back on track; you often acted as a mirror; you have often led us to ask ourselves the right questions. […] So I would say yes, there is clear added value. Could it have been more? Sure. But that depends on the desire of the organization. (Manager)

cxiv. Your questions were always pertinent, thoughtful, and meaningful. You helped lead people to say, "Are we on track" or "are we in the process of derailing." For me, that helped a lot. We would be lost; we would have gotten lost more than once without your research and without your interventions. (Director)

cxv. Action research helped us to refocus and gave us the possibility of reorganizing our priorities as well. (Executive Director)

cxvi. Even the best feedback provided from a research project can't bring anything more to the organization if the organization is not willing to use it for the right reasons and in real time. (Senior Manager)

cxvii. So far, I don't think we've succeeded in leading and coordinating the research platforms in our activities properly. I'd say it is a neutral effect for now. I still think that there is a lot of potential though, and we are close to realizing this potential. I'm eager to see if we will be able to operationalize it in our actions. (Executive Director)

cxviii. You went beyond research. In my opinion, you were almost like a coach. That is what I think. That is my impression. Maybe you'll say that it was your role but still, I believe you played a dual role. It was almost as if you were a consultant who was hired by CIUSSS to help. (Manager)

cxix. I believe that if it had not been for the action research project—that if you weren't there with your external perspective, your weekly and daily mirror, if there were no objectification and forced questioning of our ways—there wouldn't even be any attempt to deploy a management system. (Director)

APPENDIX B
DETAILS OF SPCHUS (PGM100)

CHUS Centre hospitalier universitaire de Sherbrooke

Avec vous, pour la Vie

Système Performance CHUS

PROGRAMME PGM100

DÉPLOIEMENT DU SYSTÈME DE PERFORMANCE DU CENTRE HOSPITALIER UNIVERSITAIRE DE SHERBROOKE

Plan détaillé du programme

Version 1.10 – 7 novembre 2013

TABLE DES MATIÈRES

HISTORIQUE DES VERSIONS

VERSION	DATE	AUTEUR	DESCRIPTION DES CHANGEMENTS
0.02	2013-10-03	Richard Godue	Première ébauche
0.03	2013-10-07	Richard Godue	Pour présentation aux directeurs 8 octobre
0.04	2013-10-09	Richard Godue	À la suite de la rencontre des directeurs
0.10	2013-10-16	Richard Godue	À la suite de la rencontre des directeurs
0.11	2013-10-18	Richard Godue	Développement des versions
0.20	2013-10-21	Richard Godue	À la suite de la rencontre ST et LH
0.30	2013-10-23	Richard Godue	À la suite de la rencontre équipe de projet
0.40	2013-10-24	Richard Godue	Divers
0.50	2013-10-25	Richard Godue	Divers
1.00	2013-10-25	Richard Godue	À la suite de la rencontre des directeurs
1.10	2013-11-07	Richard Godue	Le projet devient le programme PGM100 Correction de coquilles

SECTION 1 IDENTIFICATION		
Établissement	Centre hospitalier universitaire de Sherbrooke	
Agence	Estrie	
Nom et coordonnées du directeur général de l'établissement	Patricia Gauthier pgauthier.chus@ssss.gouv.qc.ca	819 346-1110 poste 23540
Répondant du déploiement Lean Santé phase II auprès du MSSS	Richard Godue rgodue.chus@ssss.gouv.qc.ca	819 346-1110 poste 16131
Substitut(s)	Nom Courriel	Téléphone
Date de dépôt du document	25 octobre 2013	

SECTION 2 MISE À JOUR DE L'INFORMATION
La désignation du projet a changé de « système de gestion intégrée de la performance (SGIP) » à « système de performance du Centre hospitalier universitaire de Sherbrooke (SPChus) ».

SECTION 3 VISION, FINALITÉ, ENJEUX, ORIENTATIONS ET OBJECTIFS	
Enjeu 1 :	L'amélioration continue
Enjeu 2 :	Le leadership transformationnel
Enjeu 3 :	Les quatre volets de la performance du CHUS
Enjeu 4 :	Des projets porteurs de valeur pour les patients
Enjeu 5 :	Les trajectoires-patients

LA VISION ORGANISATIONNELLE

« Vers un CHUS plus performant et inspirant, à dimension humaine »

LA FINALITÉ DU PROJET DE TRANSFORMATION

« De façon transversale à travers toutes les directions, améliorer les trajectoires-patients par des processus efficients, des ressources utilisées judicieusement, des personnes engagées envers leurs pratiques et des soins et services accessibles et de qualité pour les patients. »

Cette amélioration se traduira par une plus grande mobilisation du personnel, des gestionnaires et des médecins envers les patients.

ENJEU 1
L'AMÉLIORATION CONTINUE

Orientation 1.1
Mettre en œuvre un système d'amélioration continue

OBJECTIFS		INDICATEURS	CIBLES
1.1.1	Déployer le modèle CHUS d'amélioration continue au quotidien de la performance (ACQP)[1] dans les secteurs d'activités cliniques (SAC) et les services associés	▪ Nombre de secteurs déployés ▪ Nombre de services associés déployés	▪ 30 % des secteurs identifiés ▪ 30 % des services associés identifiés

Orientation 1.2
Habiliter l'organisation à l'amélioration continue

OBJECTIFS		INDICATEURS	CIBLES
1.2.1	Former les cadres intermédiaires et les cadres supérieurs de l'organisation à l'amélioration continue	▪ Nombre de cadres formés	▪ 100 %
1.2.2	Assurer la formation d'une ressource qualifiée (*ceinture verte* ou équivalent) par programme-clientèle et par direction	▪ Nombre de ressources formées ceinture verte ou équivalent	▪ Tous les programmes-clientèles et toutes les directions comptent une ressource formée ceinture verte ou l'équivalent
1.2.3	Dispenser une formation de base aux chefs médicaux	▪ Nombre de chefs médicaux formés	▪ 100 %
1.2.4	Former toutes les ressources participantes au modèle CHUS[2] dans les SAC et les services déployés	▪ Nombre de ressources formées	▪ 100 %
1.2.5	Habiliter les ressources expertes à jouer leur rôle de soutien à l'amélioration continue	▪ Nombre de ressources habilitées	▪ 100%

1 Voir annexe 2
2 Voir 1.1.1

Orientation 1.3

Terminer la mise en place de la gestion de la proximité et en assurer la pérennité

OBJECTIFS		INDICATEURS	CIBLES
1.3.1	Assurer le respect de la plage horaire de 8 h à 10 h pour les cadres terrain	▪ % de respect	▪ 80 % des cadres terrain la respectent 75 % du temps et plus
1.3.2	Respecter l'horaire type CHUS	▪ % de respect	▪ 75 % du temps et plus
1.3.3	Limiter le nombre d'heures planifiées en rencontres récurrentes par une planification synchronisée	▪ % de temps passé en rencontres récurrentes	limites suivantes : ▪ 10 % du temps travaillé pour les cadres terrain ▪ 20 % pour les gestionnaires de cadres ▪ 20 % pour les cadres-conseils ▪ 20 % pour les directeurs adjoints ▪ 25 % pour les directeurs
1.3.4	Augmenter la proportion de courriels ciblés; en limiter le nombre	▪ Nombre moyen de courriels pour un échantillon choisi	▪ Diminuer de 10 %
1.3.5	Se doter une structure optimale des comités	▪ % de formulaires complétés par les instances précisant leur raison d'être, mandat, livrables et positionnement	▪ 100 % des instances ayant complété le formulaire d'ici 2 ans
1.3.6	Favoriser l'efficacité des rencontres	▪ % d'instances utilisant les outils ▪ % d'instances accompagnées pour apprécier leur mode de fonctionnement	▪ 25 % des instances rencontrées d'ici 3 ans (en débutant par les plus consommatrices de temps de gestion)
1.3.7	Se doter d'un cycle de gestion équilibré dans l'année	▪ Adoption d'un processus annuel définissant les principales activités de gestion	▪ 100 % des directions représentées dans ce cycle

ENJEU 2

LE LEADERSHIP TRANSFORMATIONNEL

Orientation 2.1

Soutenir l'appropriation et le développement par l'organisation d'une culture de performance

OBJECTIFS		INDICATEURS	CIBLES
2.1.1	Accompagner le changement de culture en gestion du changement	▪ Taux de cadres habilités à la gestion du changement ▪ % des cadres utilisant le cadre de référence (échantillon à convenir) en gestion de changement	▪ 90 % des cadres ▪ 100 % des cadres de l'échantillon
2.1.2	Élaborer une définition commune d'organisation apprenante Définir et mettre en œuvre les principes et les stratégies d'appropriation de l'organisation apprenante	▪ Taux d'appropriation	▪ 100 % des gestionnaires et MD visés
2.1.3	Soutenir la mise en place de pratiques RH en appui au leadership transformationnel (LEADS)	▪ Nombre de pratiques RH mises en place	▪ Nombre de pratiques à déterminer
2.1.4	Adopter les mesures de pérennisation des résultats obtenus	▪ Nombre de mesures	▪ À déterminer

Orientation 2.2

Développer les compétences des gestionnaires et de leurs équipes au leadership transformationnel

OBJECTIFS		INDICATEURS	CIBLES
2.2.1	Statuer sur le rôle attendu du gestionnaire LEADS et le déployer	▪ Rôle attendu identifié et adopté par le CHUS	▪ N/A
2.2.2	Habiliter les cadres au LEADS dirigé dans un milieu de soins	▪ Nombre de cadres habilités	▪ 100 % des cadres
2.2.3	Offrir un programme de *coaching* aux gestionnaires pour l'intégration des pratiques LEADS au quotidien	▪ Programme de *coaching* élaboré et disponible	▪ N/A

Orientation 2.3
Soutenir la transformation de la gouvernance

OBJECTIFS		INDICATEURS	CIBLES
2.3.1	Soutenir le développement d'une cogestion médico-clinico-administrative intégrée (gestion en tandem)	▪ Nombre de programmes	▪ 11 programmes clientèle
2.3.2	Développer aux 3 niveaux (stratégique, tactique, opérationnel) un modèle de gouvernance impliquant les gestionnaires et les chefs médicaux, et répondant aux besoins et à la réalité du nouveau modèle de performance du CHUS	▪ Modèle élaboré et approuvé	▪ N/A

ENJEU 3
LES QUATRE VOLETS DE LA PERFORMANCE DU CHUS

Orientation 3.1
Intégrer les quatre volets de la performance aux processus de gouvernance de l'organisation

OBJECTIFS		INDICATEURS	CIBLES
3.1.1	Doter les gestionnaires et les chefs médicaux de tous les niveaux d'outils de gestion leur permettant d'appliquer le concept de performance	▪ Nombre de gestionnaires et de chefs médicaux disposant des outils	▪ 100 % des gestionnaires et des chefs médicaux
3.1.2	Habiliter les gestionnaires et les chefs médicaux à l'utilisation de l'outil d'analyse et d'aide à la décision	▪ Nombre de gestionnaires et de chefs médicaux habilités à l'utilisation de l'outil	▪ 100 % des gestionnaires et des chefs médicaux
3.1.3	Intégrer les quatre volets de la performance à tous les cadres de référence	▪ Nombre de cadres de références touchés	▪ 100 % des cadres de référence

Orientation 3.2
Mesurer la performance de l'organisation en fonction des quatre volets

OBJECTIFS		INDICATEURS	CIBLES
3.2.1	Élaborer une structure de gouvernance des indicateurs	▪ Structure de gouvernance élaborée	▪ 1
3.2.2	Mettre en œuvre en lien avec la structure un processus de pilotage des indicateurs de performance	▪ Nombre de processus de pilotage mis en œuvre	▪ 1 par niveau (stratégique, tactique, opérationnel)
3.2.3	Doter les gestionnaires et les chefs médicaux des trajectoires-patients stratégiques des indicateurs requis pour mesurer la performance de leurs trajectoires, de même que des outils de suivi	▪ Nombre de gestionnaires et de chefs médicaux disposant des indicateurs	▪ 100 % des gestionnaires des et des chefs médicaux trajectoires-patients

ENJEU 4
DES PROJETS PORTEURS DE VALEUR POUR LES PATIENTS

Orientation 4.1
Assurer l'alignement des projets avec la planification stratégique

OBJECTIFS		INDICATEURS	CIBLES
4.1.1	Mettre en place un portefeuille des projets de développement au CHUS	▪ Portefeuille en place	▪ 1
4.1.2	Mettre en place les processus de gestion du portefeuille, identifier les parties prenantes à ces processus, de même que leurs rôles et responsabilités, et fournir les outils nécessaires	▪ Nombre de processus	▪ Les processus de base prescrits
4.1.3	Respecter les capacités de l'organisation dans la réalisation des projets	▪ Taux de ressources affectées aux projets de développement	▪ 20%
4.1.4	Mettre au point un plan de communication relativement au portefeuille de projets	▪ Plan de communication en place	▪ 1

Orientation 4.2
S'assurer de mesurer la contribution des projets aux objectifs d'affaires auxquels ils sont associés

OBJECTIFS		INDICATEURS	CIBLES
4.2.1	Mettre en place, à tous les niveaux, les processus de suivi des projets, identifier les parties prenantes à ces processus, de même que leurs rôles et responsabilités, et fournir les outils nécessaires	▪ Processus en place	▪ 4
4.2.2	Mesurer périodiquement la contribution des projets aux objectifs d'affaires auxquels ils sont associés, en particulier ceux des trajectoires-patients	▪ Cycle de gestion en place	▪ 1
4.2.3	Communiquer les résultats et mettre à jour les tableaux correspondants de la salle exécutive	▪ Plan de communication en place	▪ 1

ENJEU 5
LES TRAJECTOIRES-PATIENTS

Orientation 5.1
Améliorer la performance des trajectoires-patients stratégiques

OBJECTIFS		INDICATEURS	CIBLES
5.1.1	Définir le concept de trajectoire patient, produire un cadre de référence, identifier les trajectoires stratégiques et développer un modèle transversal de fonctionnement des trajectoires stratégiques	▪ Nombre de trajectoires stratégiques identifiées en accord avec le cadre de référence	▪ 2
5.1.2	Cartographier et modéliser les trajectoires stratégiques[3], faire les mesures t0, identifier les problèmes et les solutions à apporter, cibler les indicateurs, mettre en œuvre les projets d'amélioration requis, mesurer les résultats obtenus et ajuster le tir	▪ Selon la liste qui sera constituée en 5.1.2	▪ À déterminer

Orientation 5.2
Instaurer une gouvernance transversale, systémique et intégrée des trajectoires-patients stratégiques

OBJECTIFS		INDICATEURS	CIBLES
5.2.1	Développer dans chaque direction une compréhension commune du concept de trajectoire-patient, et leur permettre de s'approprier leur responsabilités	▪ Nombre de directions s'étant approprié le concept de trajectoire-patient	▪ 100 %
5.2.2	Développer chez les gestionnaires et les chefs médicaux une approche systémique permettant d'identifier l'impact de leurs décisions sur les processus en amont et en aval et les outiller afin d'identifier et d'évaluer cet impact	▪ Nombre de gestionnaires et de chefs médicaux intégrés à l'approche et outillés	▪ 100 %
5.2.3	Identifier chaque niveau de gouvernance des sous-trajectoires, les munir d'indicateurs et de cibles adéquats, mettre en place les systèmes et les outils nécessaires et développer un modèle transversal de gouvernance des trajectoires stratégiques	▪ Nombre de niveaux de gouvernance habilités et équipés	▪ 100 %

[3] Selon la méthode de la gestion de la chaîne de valeur (Value Stream Mapping)

Orientation 5.3

Structurer l'intégration systématique de l'expérience des patients dans nos processus d'amélioration de la performance

OBJECTIFS		INDICATEURS	CIBLES
5.3.1	Systématiser la prise en considération de l'expérience-patient dans les processus d'amélioration continue au quotidien de la performance	▪ Nombre de secteurs d'activités cliniques (SAC) où le changement de culture est intégré	▪ 100 % des SAC déployées
5.3.2	Intégrer des patients collaborateurs au sein des équipes de projet de toutes natures, et plus spécifiquement des projets d'amélioration continue, lorsque pertinent	▪ Taux de projets pertinents ayant intégré les patients collaborateurs au sein de leurs équipes	▪ 100 % des projets pertinents

SECTION 4 DESCRIPTION DU DÉPLOIEMENT DE NOTRE TRANSFORMATION ORGANISATIONNELLE

Stratégie de déploiement du système de performance du CHUS

La stratégie de déploiement du système de performance du CHUS s'appuie sur trois approches :

- intensive : la mise en place d'un modèle de gestion transversale, systémique et intégrée des trajectoires-patients;
- extensive : le déploiement, dans les secteurs d'activités cliniques et les services associés identifiés, du modèle CHUS d'amélioration continue au quotidien de la performance (voir annexe 1);
- organisationnelle : concerne toutes les initiatives menant à la conception et à la mise en place d'un nouveau modèle de gouvernance du CHUS.

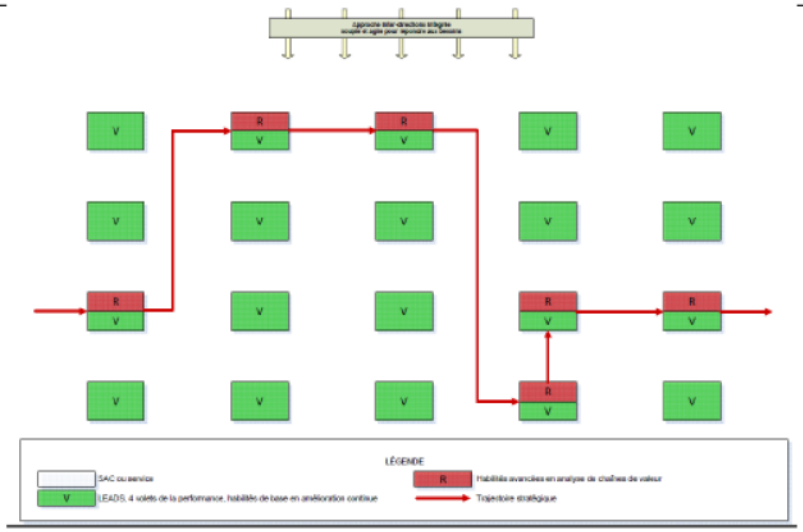
Les composantes du déploiement :

- la mise en place d'éléments de gouvernance;
- l'habilitation des ressources au leadership transformationnel, aux quatre volets de la performance et à l'amélioration continue, aux niveaux opérationnel, tactique et stratégique;
- la mise en place de cadres de références, d'outils et de techniques.

Schéma illustratif :

Le schéma qui suit illustre un certain nombre de secteurs d'activités cliniques (SAC) et de services associés faisant l'objet du déploiement du système de performance du CHUS. Les différentes couleurs font référence à l'intensité des moyens mis en œuvre pour réaliser le déploiement et en assurer la pérennisation :

- le vert illustre une intensité de niveau léger, approprié pour un déploiement extensif visant la « contamination » de l'organisation;
- le rouge illustre les habilités supplémentaires requises afin de résoudre les problématiques plus complexes qui seront rencontrées sur les trajectoires-patients stratégiques.



Le tableau suivant résume les différents paramètres du déploiement associés aux trois approches décrites précédemment :

Objectif du déploiement	Approche adoptée	Lieux visés	Intensité du déploiement	Niveau(x) de gouvernance	Niveau d'autonomie du SAC	Niveau d'impact	Approche de déploiement[4]
Mise en place d'un modèle de gestion transversale, systémique et intégrée des trajectoires-patients	Conception du modèle et pilotage sur deux trajectoires stratégiques	SAC et services associés	Lourde	Stratégique et tactique	Faible	Organisa-tionnel	Intensive
Déploiement du modèle CHUS d'amélioration continue au quotidien de la performance[5]	« Contamination » de l'organisation	SAC et services associés	Modérée	Opérationnel	Élevé	Local	Extensive
Mise en place d'un modèle organisationnel de gouvernance répondant aux besoins et à la réalité du nouveau système de performance du CHUS[6]	Conception du modèle de gouvernance et habilitation des ressources concernées	Tous	N/A	Stratégique, tactique et opérationnel	N/A	Organisa-tionnel	Organisa-tionnelle

[4] Voir lettre d'intention p. 12
5 Voir annexe 2
6 Voir objectif 2.3.2

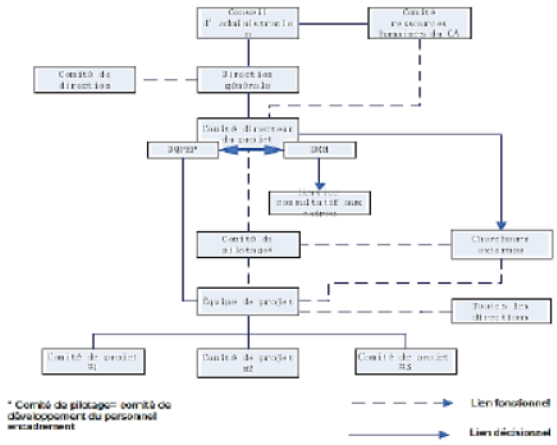
SECTION 5
Voir la section 3

SECTION 6 LES PROJETS		
Objectifs 1.1.1, 1.2.4, 1.2.5		
Programme PGM101-101 : Déployer le modèle d'ACQP dans les secteurs d'activités cliniques et certains services associés Nombre de projets : Environ une trentaine (à préciser)	Nouveau programme	Date de début : 2013-11-01 Date de fin prévue : 2016-03-22
Objectif 1.2.1		
Projet P101_101 : former les cadres intermédiaires et supérieurs à l'amélioration continue	Nouveau projet	Date de début : Date de fin prévue :
Objectif 1.2.2		
Projet P101_102 : compléter la 3e cohorte de formation à l'UQTR	Projet en cours	Date de fin prévue : 2013-12-20
Objectif 1.2.3		
Projet P101_103 : former les chefs médicaux	Projet en cours	Date de fin prévue :
Objectifs 1.3.1 à 1.3.7		
Projet P101_104 : mettre en place la gestion de proximité	Projet en cours	Date de fin prévue : 2014-05-30
Objectif 2.1.2		
Projet P101_201 : mettre en place une organisation apprenante	Projet en cours	Date de fin prévue :
Objectifs 2.1.1, 2.1.3, 2.1.4		
Projet P101_202 : installer une culture de la performance	Projet en cours	Date de fin prévue :
Objectifs 2.2.1, 2.2.2, 2.2.3		
Projet P101_203 : développer les compétences des gestionnaires et des chefs médicaux	Projet en cours	Date de fin prévue :
Objectif 2.3.1		
Projet P101_204 : soutenir la cogestion	Nouveau projet	Date de début : Date de fin prévue :
Objectif 2.3.2		
Projet P101_205 : déployer un nouveau modèle organisationnel de gouvernance	Projet en cours	Date de fin prévue : 2014-08-06
Objectifs 3.1.1, 3.1.2		
Projet P101_301 : équiper les gestionnaires et les chefs médicaux et les habiliter aux outils de gestion de la performance	Nouveau projet	Date de début : Date de fin prévue :
Objectif 3.1.3		
Projet P101_302 : intégrer les 4 volets dans les cadres de référence	Projet en cours	Date de fin prévue :

Objectif 3.2.1, 3.2.2, 3.2.3		
Projet P101_303 : installer la mesure de la performance de l'organisation	**Projet en cours**	**Date de fin prévue :**
Objectifs 4.1.1, 4.1.2, 4.1.3, 4.1.4		
P101_401 : assurer l'alignement des projets à la planification stratégique	**Projet en cours**	**Date de fin prévue :**
Objectifs 4.2.1, 4.2.2, 4.2.3		
P101_402 : mesurer la contribution des projets aux objectifs de l'organisation	**Nouveau projet**	**Date de début :** **Date de fin prévue :**
Objectifs 5.1.1, 5.1.2, 5.1.3		
Programme P101-501 : implanter un modèle de gestion transversal, intégré et systémique des trajectoires-patients stratégiques. Plusieurs projets d'amélioration continue sont à prévoir ; le nombre sera déduit du VSM	**Programme en cours**	**Date de fin prévue : 2016-03-22**
Objectifs 5.2.1, 5.2.2, 5.2.3		
Projet P101-501_01 : installer une gouvernance des trajectoires-patients	**Nouveau projet**	**Date de début : 2014-01-06** **Date de fin prévue : 2016-03-22**
Objectifs 5.3.1, 5.3.2		
Projet P101_502 : intégrer l'expérience-patient	**Projet en cours**	**Date de fin prévue : 2016-03-22**

SECTION 7 STRUCTURE DE GOUVERNANCE ACTUELLE

La figure qui suit représente la structure de gouvernance mise en place pour le projet GPS. Cette structure sera remplacée par une nouvelle structure de gouvernance de la transformation organisationnelle.



SECTION 8 ORGANISATION ET COMPOSITION DE L'ÉQUIPE LEAN ACTUELLE

Responsable hiérarchique :

M. Yvon Paris, directeur
Direction des ressources financières et des services techniques (DRFST)

Coordonnateur :

M. Sylvain Chaussé, conseiller cadre à l'amélioration continue, TCP

Agents-conseils :

5 TCT

Agente administrative classe 1 :

1 TCT

SECTION 9 SOUTIEN FINANCIER		
ÉQUIPE DE PROJET	NOMBRE	SOMMES PRÉVUES
Agent *Lean*	2 ETC – 2 ans	240 K$
Conseiller en communication	1 ETC – 2 ans	160 K$
Agent de soutien aux changements	1 ETC – 2 ans	160 K$
Conseiller qualité	1 ETC – 2 ans	160 K$
Spécialiste en intelligence d'affaires	1 ETC – 2 ans	160 K$
Ressource en TI	1 ETC – 2 ans	160 K$
Conseillère cadre clinique	1 ETC – 2 ans	160 K$
Médecin	0.5 ETC – 2 ans	200 K$
Libération du personnel Coûts de remplacement : diplômés de l'UQTR		100 K$
Développement de compétence Remplacements – Formation du personnel (équipe) Coordonnateur des formations (agendas, logistique, matériel, guides, etc.)		160 K$
Soutien et logistique (excluant immobilisation et TI) Environnement LEAN des secteurs d'activités cliniques		50 K$
Honoraire externe 1 chef de projet à temps complet 2 ans Consultant(s)- formateur(s) externe(s) 1 chargé de projets – 0.6 ETC – 6 mois		220 K$ 100 K$ 30 K$
Accompagnement et transfert de connaissances Candidate au DBA, UdeS, Mario Roy, directeur de thèse Soutien financier de 4e année[7]		30 K$
TOTAL		**2 090 K$**
Contribution ministérielle attendue		**1 400 K$**
Contribution CHUS		**690 K$**

[7] Les trois premières années seraient couvertes par un budget discrétionnaire du MSSS à raison de 30 k$ par an

SECTION 10 INFORMATION ADDITIONNELLE, COMMENTAIRES

Volet supplémentaire au projet

Dans le cadre de son *programme de doctorat en administration conduisant au grade de DBA*[8], l'Université de Sherbrooke offre au CHUS de doubler le projet actuel de déploiement de son système de performance, d'un projet de recherche-action portant sur l'implantation d'une culture d'amélioration continue dans un établissement de santé québécois. Une candidate au doctorat, Mme Johanne Roberts, est pressentie à titre de responsable du projet, sous la supervision de M. Mario Roy, professeur titulaire de la *Chaire d'étude en organisation du travail* du *Département de management et gestion des ressources humaines* de l'Université de Sherbrooke.

Mme Roberts détient un diplôme de bachelière ès sciences, option génie mécanique, de la *Queen's University*, de Kingston, Ontario (1998). En plus de diverses formations en Lean, elle détient une certification d'ingénieure Six Sigma, de même qu'une formation en cartographie de la chaîne de valeur (VSM). Au plan professionnel, Mme Roberts a occupé des postes de haute direction, entre autres, celui de directrice générale de la *Corporation Baxter* à Sherbrooke, fonction qu'elle a occupée de 2003 à 2012. La participation pressentie de Mme Roberts au projet prendrait deux formes : l'accompagnement du projet et le transfert de connaissances. Elle intéresse grandement le CHUS.

Une première rencontre avec M. Roy a permis d'établir que le projet CHUS possède une envergure, un niveau de complexité et des composantes novatrices[9] propres à soutenir une initiative de niveau doctorat. Il est également apparu que la synchronisation des calendriers respectifs du CHUS et de la doctorante serait réalisable, compte tenu du fait que cette dernière a déjà entrepris sa formation théorique de première année sur une durée prévue de quatre ans.

Le CHUS considère qu'il s'agit d'une excellente opportunité de développement des connaissances en Lean-santé qui peut avoir des retombées non seulement pour son établissement, mais également pour tous les établissements qui participent à cette deuxième phase de projet Lean-santé et ultimement, pour l'ensemble des établissements du Québec. Dans ce contexte, le CHUS s'engage à valider avec le Ministère les activités de transfert des connaissances au niveau national qui feront partie de l'entente avec l'Université de Sherbrooke.

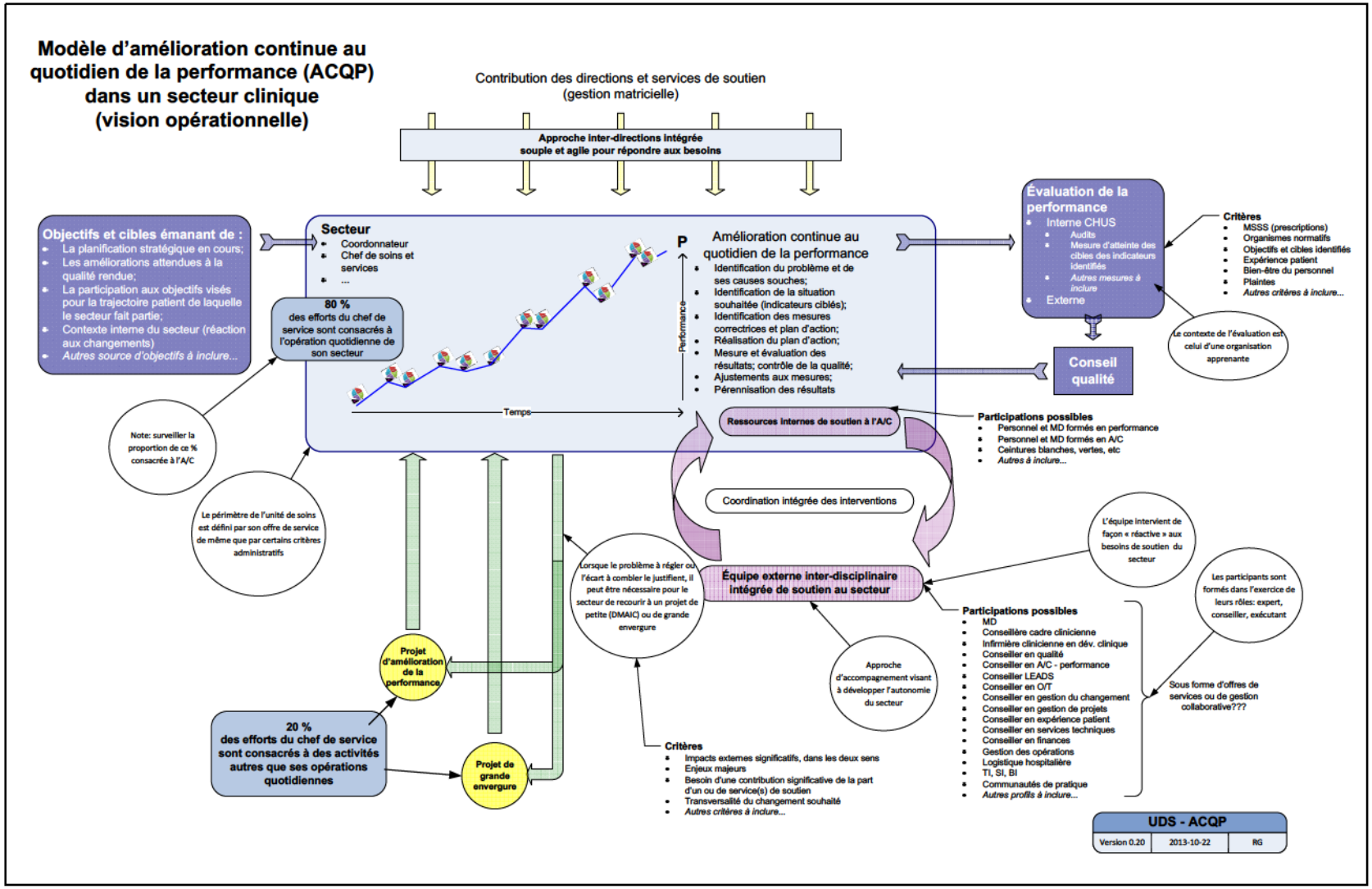
En conséquence, le CHUS demande — en marge du financement disponible dans le cadre de l'actuel projet, et ce, pour la même période pouvant s'échelonner sur trois ans — un appui financier additionnel de l'ordre de 90 000 $ (30 000 $ par année), afin de soutenir financièrement Mme Roberts, et de 5 000 $ pour couvrir des activités de transfert des connaissances au cours de ces trois années.

8 DBA : *Doctorate in business administration*

9 Une de ces composantes consisterait à analyser l'intérêt et la faisabilité d'adapter les méthodes de gestion des opérations (MRP2 ou autres) à la réalité d'un centre hospitalier comme le CHUS. Une autre consisterait en la mise en place d'un pôle de gestion collaborative comme mécanisme permanent de soutien aux SAC et services associés en amélioration continue. Voir lettre d'intention de mai 2013 p. 14, renvois 12 et 11.

ANNEXE 1
LE MODÈLE CHUS D'AMÉLIORATION CONTINUE

La vision opérationnelle du modèle CHUS de l'amélioration continue au quotidien de la performance (ACQP) représente, à haut niveau, la façon dont les secteurs d'activités cliniques (SAC) et les services associés déployés fonctionneront au quotidien, une fois leur déploiement sera complété et les mesures implantées pérennisées. La figure de la page suivante représente un SAC, mais le modèle sera adapté pour un service hospitalier.


Modèle d'amélioration continue au quotidien de la performance (ACQP) dans un secteur clinique (vision opérationnelle)
Contribution des directions et services de soutien (gestion matricielle)
Approche inter-directions intégrée souple et agile pour répondre aux besoins
Objectifs et cibles émanant de :
La planification stratégique en cours;
Les améliorations attendues à la qualité rendue;
La participation aux objectifs visés pour la trajectoire patient de laquelle le secteur fait partie;
Contexte interne du secteur (réaction aux changements)
Autres source d'objectifs à inclure...
Secteur
Coordonnateur
Chef de soins et services
...
80 %
des efforts du chef de service sont consacrés à l'opération quotidienne de son secteur
Note: surveiller la proportion de ce % consacrée à l'A/C
Le périmètre de l'unité de soins est défini par son offre de service de même que par certains critères administratifs
P
Performance
Temps
Amélioration continue au quotidien de la performance
Identification du problème et de ses causes souches;
Identification de la situation souhaitée (indicateurs ciblés);
Identification des mesures correctrices et plan d'action;
Réalisation du plan d'action;
Mesure et évaluation des résultats; contrôle de la qualité;
Ajustements aux mesures;
Pérennisation des résultats
Ressources internes de soutien à l'A/C
Coordination intégrée des interventions
Équipe externe inter-disciplinaire intégrée de soutien au secteur
Évaluation de la performance
Interne CHUS
Audits
Mesure d'atteinte des cibles des indicateurs identifiés
Autres mesures à inclure
Externe
Critères
MSSS (prescriptions)
Organismes normatifs
Objectifs et cibles identifiés
Expérience patient
Bien-être du personnel
Plaintes
Autres critères à inclure...
Le contexte de l'évaluation est celui d'une organisation apprenante
Conseil qualité
Participations possibles
Personnel et MD formés en performance
Personnel et MD formés en A/C
Ceintures blanches, vertes, etc
Autres à inclure...
L'équipe intervient de façon « réactive » aux besoins de soutien du secteur
Les participants sont formés dans l'exercice de leurs rôles: expert, conseiller, exécutant
Sous forme d'offres de services ou de gestion collaborative???
Participations possibles
MD
Conseillère cadre clinicienne
Infirmière clinicienne en dév. clinique
Conseiller en qualité
Conseiller en A/C - performance
Conseiller LEADS
Conseiller en O/T
Conseiller en gestion du changement
Conseiller en gestion de projets
Conseiller en expérience patient
Conseiller en services techniques
Conseiller en finances
Gestion des opérations
Logistique hospitalière
TI, SI, BI
Communautés de pratique
Autres profils à inclure...
Approche d'accompagnement visant à développer l'autonomie du secteur
Lorsque le problème à régler ou l'écart à combler le justifient, il peut être nécessaire pour le secteur de recourir à un projet de petite (DMAIC) ou de grande envergure
Projet d'amélioration de la performance
20 %
des efforts du chef de service sont consacrés à des activités autres que ses opérations quotidiennes
Projet de grande envergure
Critères
Impacts externes significatifs, dans les deux sens
Enjeux majeurs
Besoin d'une contribution significative de la part d'un ou de service(s) de soutien
Transversalité du changement souhaité
Autres critères à inclure...
UDS - ACQP
Version 0.20
2013-10-22
RG

ANNEXE 2
STRATÉGIE DE DÉPLOIEMENT

Le déploiement de la transformation organisationnelle sera réalisé sur trois approches, chacune d'entre elles reprenant, à des degrés divers, des initiatives en cours.

1) L'approche extensive (enjeux 1, 2 et 3)

Le modèle à déployer :

Au cours des dernières semaines, le CHUS a développé une vision opérationnelle d'un système intégré d'amélioration continue au quotidien de la performance (ACQP) de ses secteurs d'activités cliniques (SAC). Cette vision intègre la participation complémentaire et interdisciplinaire des forces vives de l'organisation en matière d'amélioration continue, autant cliniques[10] que spécialisées en processus, en gestion du changement ou en qualité.

De cette vision a émané un **modèle type du fonctionnement au quotidien d'un secteur d'activités cliniques en mode d'ACQP**; ce modèle est décrit sommairement en annexe 1. Le même modèle servira également de base, à quelques ajustements près, au déploiement de l'amélioration continue dans les services associés visés.

C'est ce modèle qui fera l'objet de l'approche extensive dont il est question dans notre projet.

La forme du déploiement :

Le déploiement sera réalisé sous la forme d'un programme[11] subdivisé en autant de projets que de secteurs d'activités cliniques et de services associés à déployer. La gestion en programme assurera l'uniformité du modèle déployé dans chacun des SAC et des services associés, alors que chaque projet permettra la participation des ressources locales concernées. Le déploiement sera réalisé selon une priorisation qui permettra d'augmenter les chances de succès de la démarche et de pérenniser les résultats obtenus.

[10] Conseillères cadres cliniciennes (CCC), Infirmières cliniciennes de développement clinique (ICDC)
[11] Programme: au sens du PMI d'un ensemble de projets concourant à des objectifs et des bénéfices attendus communs

Le déploiement sera réalisé de façon agile, par itérations successives chacune composée de trois étapes :

- observation du secteur ou du service et planification de l'intervention;
- implantation du modèle;
- soutien à la pérennisation des résultats obtenus (stabilisation).

Une transformation dans l'action

Fidèle à son orientation de se transformer dans l'action, le CHUS a choisi de prioriser, entre autres critères, les SAC où des pratiques organisationnelles requises (POR) doivent être améliorées afin d'assurer des soins et des services de qualité à ses patients, et d'ainsi se conformer aux exigences d'Agrément Canada. Dans ces secteurs, la conformité aux POR deviendrait l'un des résultats attendus du secteur déployé.

2) L'approche intensive (enjeux 1, 2, 3, 4 et 5)

Portée de l'approche intensive

L'approche intensive vise les trajectoires-patients stratégiques identifiées par l'organisation pour la mise en œuvre de son projet de transformation. À cet effet, il est prévu de déployer deux (2) trajectoires dans le contexte du présent projet. La première trajectoire sera l'oncologie qui servira d'expérience pilote; la seconde reste à identifier. Selon les résultats obtenus, il est possible que d'autres trajectoires-patients stratégiques s'ajoutent.

Cet approche est qualifiée d'intensive du fait qu'en plus d'inclure le déploiement du modèle opérationnel mentionné précédemment dans les secteurs d'activités cliniques participants aux trajectoires, une nouvelle approche doit être développée afin d'assurer une gestion systémique, transversale et intégrée de ces secteurs. Le modèle dont il est question ici, qui est spécifique aux trajectoires stratégiques, reste à développer. Il sera la résultante des orientations 5.1 et 5.2.

La forme du déploiement

Le déploiement du modèle se fera sous forme de programme, à raison d'un projet par trajectoire stratégique à déployer. Le programme assurera l'uniformité de l'approche et du modèle de même que le transfert des connaissances, alors que les projets permettront la participation des parties prenantes concernées dans chacune des trajectoires.

L'approche

Pour chacune des trajectoires stratégiques retenues, une cartographie de la trajectoire sera réalisée sous la forme d'une analyse de la chaîne de valeur (VSM) (objectif 5.1.3). Les résultats obtenus de cet exercice serviront à :

- identifier les problèmes et les possibilités d'amélioration de la performance de la trajectoire;
- identifier les pistes de solutions à apporter;
- identifier les parties prenantes à leur mise en œuvre;
- identifier les meilleurs méthodologies, outils et techniques ou ensembles de méthodologies, d'outils et de techniques auxquels recourir pour chacune des solutions à apporter;
- définir un plan de mise en œuvre des solutions.

Il est à prévoir que des réingénieries de processus, de même que des sous-projets d'amélioration continue (DMAIC) soient requis. Ces sous-projets seront identifiés et mis en œuvre au fur et à mesure de l'avancement de l'analyse des trajectoires stratégiques.

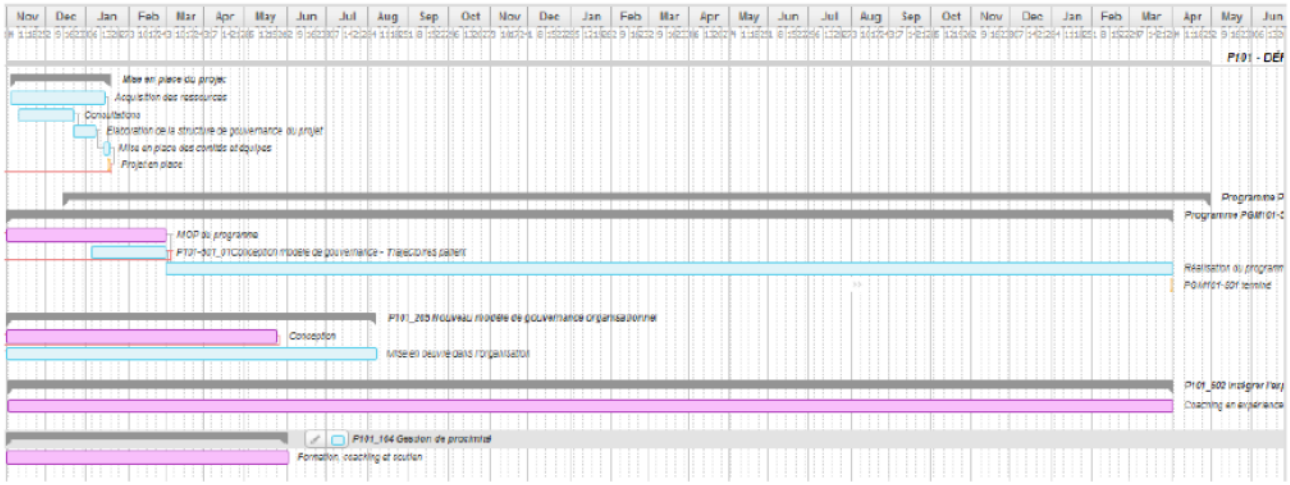
Une nouvelle gouvernance

L'approche intensive inclut finalement la mise en œuvre d'une gouvernance spécifique aux trajectoires-patients stratégiques (orientation 5.2). Cette gouvernance doit être :

- systémique : toutes les initiatives et les interventions en un point de la trajectoire doivent tenir compte de leur impact sur l'ensemble de la trajectoire, de même que sur l'organisation;
- transversale : elle doit considérer les étapes parcourues par un patient lors d'un épisode de soins comme un ensemble, plutôt que comme une succession d'étapes administratives, physiques et/ou cliniques;
- intégrée : la responsabilité de la performance d'une trajectoire stratégique incombe à l'ensemble des directions, cliniques et non cliniques; toutes sont parties prenantes et imputables de la performance.

L'approche organisationnelle

L'approche transversale considère les initiatives de portée organisationnelle, tous niveaux confondus.



Annexe 2
Stratégie de déploiement

APPENDIX C
LIST OF FIELD REFERENCES AND SECONDARY DATA CONSULTED

List of field references and secondary data consulted

PRIMARY DATA
Verbatim of 62 semi-structured individual interviews

Verbatim of two group discussions concerning the key learnings for each of the action research cycles.

Verbatim of the discussions following the presentation of the final research results.

Minutes and handwritten notes of the meetings of the committees in the governance structure for SPCHUS (two Steering Committee meetings, six Tactical Committee meetings, 33 meetings of the Development and Planning Team and 21 meetings of the Operational Deployment Team).

Handwritten notes from the session with the Senior Management Team at the CHUS to evaluate Lean Maturity in January 2015.

Handwritten notes of the global kick off meeting for deployment of SPCHUS in June 2014, and of the deployment activities observed in each of the three pilots at the CHUS. Handwritten notes of seven Open Forums at the CHUS between October 2014 and April 2015 and two Management Forums (June 2014 and February 2015).

Handwritten notes of 111 hours of meetings concerning the development of SGIP, with those tasked with the completion of the A3 document.

Minutes and handwritten notes of the meetings of the committees in the governance structure for SGIP (30 meetings of the Steering Committee, 27 meetings of the Tactical Committee and seven meetings of the Operational Committee).

Handwritten notes of ten meetings concerning the organizational identity of the CIUSSS de l'Estrie — CHUS.

Handwritten notes of the kick off meetings and subsequent activities in deployment of SGIP in four pilots at the CIUSSS de l'Estrie — CHUS.

Handwritten notes of six Management Forums at the CIUSSS de l'Estrie—CHUS from December 2015 to October 2016.

Handwritten notes from the full-day training session on Obeya management in March 2016.

Handwritten notes of the Hoshin Kanri exercise in 2016 at the CIUSSS de l'Estrie — CHUS.

Field journal with observations and reflections covering the period of the research (over 1600 pages).

SECONDARY DATA

Newspaper *La Tribune*

2013-10-31	Annonce	Le CHUS en chiffres 2012-2013
2014-06-15	Alexandre Faille	Un mandate rempli de défis pour le nouveau dg du CHUS
2014-10-15	Alain Goupil	Barette se fait rassurant : la réforme du réseau de la santé ne modifiera pas la mission du CHUS, promet le ministre
2015-03-28	Jacynthe Nadeau	Réseau de la santé en Estrie : Le grand dérangement commence.
2015-03-28	Jacynthe Nadeau	La fin de l'Agence de la santé et des services sociaux de l'Estrie
2015-06-26	Alexandre Faille	Bilan des 100 premiers jours du CIUSSS de l'Estrie — CHUS : La réorganisation est complétée
2015-06-24	Élisabeth Fleury	Des cadres de la santé à bout de souffle.

Newspaper *Le Devoir*

2015-02-11	Amélie Daoust-Boisvert	Le CHUS en chiffres 2012-2013

Newsletter of the CIUSSS de l'Estrie — CHUS *Le Lien*

Le Lien was published on a weekly basis. The editions from April 20, 2015, up to January 25, 2016, were consulted for this research.

MHSS publication *Au fil de la réorganisation : d'un réseau d'établissements à un réseau de services aux patients*

The purpose of the newsletter was to inform all the personnel of the health and social services network of the progress of the work related to the implementation of the reform to amend the organization and governance of the health and social services network, in particular by the abolition of regional agencies.

Twenty-one editions were published, and were consulted over the course of the research

Internal Documentation from the CHUS

Le LEAN management en nous… Présentation par Yvon Paris, directeur Ressources financières et services techniques au Colloque LEAN management le 26 janvier 2012. 34 pages.

Projet d'implantation de l'approche Lean Healthcare Six Sigma dans des établissements du réseau de la santé et des services sociaux. Appel de candidatures et critères d'admissibilité. Phase II. Version 0.5, 2013-05-23, 15 pages.

Programme PGM100 : Déploiement du système de performance du CHUS ; Plan détaillé du programme. Version 1.10, 7 novembre 2013, 26 pages.

Commentaires des participants à l'enjeu organisationnel du 4 juin 2014. Compilation faite par les Ressources humaines, 5 pages.

Plan stratégique 2012-2015 — Bilan. 40 pages.

Internal Documentation from the CIUSSS de l'Estrie— CHUS

Internal memo, September 26th, *Le Patient au centre de nos préoccupations*

Press Release, February 9th, 2015, *Création du CIUSSS de l'Estrie — CHUS : La population de l'Estrie est choyée.*

Mandat au bureau de transformation. Document not dated. 2 pages.

Déclaration d'engagement des membres du Conseil d'Administration du CIUSSS de l'Estrie — CHUS. Document not dated. 1 page.

Animation de la gestion par trajectoire : Atelier de réflexion avec Alain Rondeau. PowerPoint presentation dated October 15, 2015. 10 pages.

Documentation des objectifs de transformation ou de priorités organisationnelles (complémentaire aux suivis de chaque A3 tactique). Objectif de transformation/Priorité organisationnelle : Élaborer et mettre en œuvre la planification organisationnelle (A3 stratégique). Document dated October 16, 2015. 8 pages.

Planification organisationnelle. Presentation to the Board of Directors dated October 29, 2015. 7 pages.

Cycle de gestion opérationnel ; bureau de direction. December 14th, 2015. 13 pages.

Présentation des résultats du sondage sur la mobilisation des cadres du CIUSSS de l'Estrie — CHUS. December 2015. 19 pages.

Documentation des objectifs de transformation ou de priorités organisationnelles (complémentaire aux suivis de chaque A3 tactique). Objectif de transformation/Priorité organisationnelle : Implanter la gestion des trajectoires en soins et services pour en améliorer l'accès et la fluidité. Document not dated. 15 pages.

Planification des priorités essentielles à l'organisation clinique et administrative des six prochains mois. January 7, 2016. 5 pages.

Projet de déploiement d'un système de gestion de la performance en appui à l'amélioration continue des trajectoires de soins et services. February 15th, 2015. 29 pages.

Plan d'action annuel du CIUSSS de l'Estrie — CHUS : Document du travail. March 30 th, 2016. 15 pages.

Présentation des résultats du sondage sur la mobilisation des cadres du CIUSSS de l'Estrie — CHUS. May 2016. 17 pages.

Plan de développement des compétences de gestion ; entériné par le comité tactique SGIP le 29 septembre 2016. Presented to the EMC October 6, 2016. 19 pages.

Other documentation:

Points clés pour la croissance du leadership : Liste de vérification à l'intention des leaders. Document published by the Canadian Health Leadership Network, the Canadian College of Health and the LEADS collaborative. 4 pages.

Cadre de référence des salles de pilotage stratégiques et tactiques. Document issued by the MHSS dated November 2015. 20 pages.

Sens de la réforme et gouvernance clinique : Première journée du programme de soutien et d'accompagnement des hauts dirigeants. December 14th, 2015. 65 pages.

Outil d'évaluation de la maturité Lean. Pole Santé HEC Montréal et Chaire IRISS. November 17, 2014. 77 pages.

APPENDIX D
INTERVIEW GUIDES

Schéma d'entrevue pour confirmer la problématique managériale - Automne 2014

Introduction et remerciements

Familiarisation
Depuis quand est-ce que vous êtes impliqué dans le programme SPCHUS ?
Et quel était votre parcours avant ce travail ?

Historique
Pouvez-vous m'indiquer les principales étapes dans la création/évolution du programme SPCHUS ?
Qui sont les principales personnes impliquées ?
Comment est-ce que vous définissez le lean santé ?
Comment est-ce que vous définissez l'amélioration continue ?
Passez en revue le modèle ACQP et les composantes du déploiement (quel est le lien créer une organisation apprenant, stratégies de codéveloppement)

Organisation
Qui est impliqué dans l'établissement des objectifs découlant de la planification stratégique au CHUS ?
Comment est-ce que le suivi des objectifs est fait ?
Comment décriviez-vous la culture actuelle au CHUS ?
Comment est-ce que le changement sera mesuré ?
Pourquoi l'organisation veut-elle changer ?
Est-ce que le CHUS utilise un modèle de gestion de changement en particulière ?

Gestionnaires
Quelle est la réalité des gestionnaires ?
Comment est-ce que l'outil d'analyse et d'aide à la décision est perçu ?
Quel est le niveau de compréhension de Lean au travers de l'organisation ?
Quel est le style de gestion utilisé généralement dans l'organisation ?
Jusqu'à quel point la façon dont la direction exerce son autorité est-elle perçue comme étant correcte et appropriée ?
D'où viennent les cadres, sont-ils compétents sur le plan administratif, technique, gestion des personnes ? sont-ils motivés, satisfaits bien intégré à l'entreprise ?
Jusqu'à quel point les cadres de premier niveau ont-ils de l'autonomie dans leur prise de décision ?

Remerciements

Entrevue sur l'avancement de SPCHUS – Apprentissages 1er cycle

Objectif : faire le point une année après l'introduction de SPCHUS ; avoir des données plus formelles pour être en mesure de faire la triangulation avec mes notes d'observation, discussions informelles et révision de la documentation.

Personnes ciblées :
Entrevues individuelles :
Direction général, chef de programme SPCHUS, expert-conseil, SPCHUS, membres du comité exécutif, gestionnaires sur le terrain, professionnels de l'amélioration continue.

Groupe de discussion :
Groupe de conception et planification

Questions :

- Considérant la finalité souhaitée avec SPCHUS, comment qualifierez-vous le progrès fait à date ?
- Quelles ont été les décisions et actions marquantes dans le déploiement du SPCHUS au cours de la dernière année ?
- Quels ont été les événements (internes/externes) qui ont influencé l'évolution du déploiement du SPCHUS ?
- Quels apprentissages est-ce que l'organisation peut en tirer de la dernière année de travail sur le SPCHUS ?
- Quels sont les plus grands enjeux à la réussite du SPCHUS ?
- Quel est le niveau de priorité du SPCHUS parmi l'ensemble des priorités de l'organisation ?
- Comment qualifieriez-vous votre motivation à vous investir dans le déploiement du SPCHUS ? Et comment qualifieriez-vous les chances de réussite du déploiement ?
- Étant donné les évènements marquants, les apprentissages et les enjeux, qu'est ce que vous prévoyez faire dans la poursuite du déploiement du SPCHUS au cours du prochain trimestre ?

Remerciements

Entrevue sur les chantiers de transformation « gestion par trajectoire » et SGIP — Guide d'entrevue préparer par le CIUSSS de l'Estrie - CHUS

En vue d'alimenter les prochains travaux du chantier de transformation « volet trajectoire », les responsables stratégiques et tactiques ont besoin de connaître le niveau de compréhension et d'affiliation de leurs équipes impliquées dans les trajectoires. C'est pourquoi les propriétaires de trajectoire et les directeurs contributeurs sont convoqués à cette entrevue de 30 minutes afin de répondre à une dizaine de questions.

Votre compréhension du « QUOI »

Si vous aviez à expliquer dans un ascenseur ce qu'est la gestion par trajectoire de soins et services, vous diriez ?

Qu'est-ce que cela changera pour vous comme gestionnaire ?

Sur une échelle de 1 à 5, comment qualifiez-vous le niveau de compréhension de la gestion par trajectoire par les directeurs ?

1 2 3 4 5

Compréhension faible — Compréhension totale

Votre affiliation au « POURQUOI »

Pourquoi selon vous notre organisation souhaite-elle transformer son mode de gestion ? Quels problèmes tentons-nous de résoudre ? De quoi nos patients souffrent-ils ?

Pourquoi selon vous c'est la solution « trajectoire » qui a été choisie ?

Quels seront les bénéfices ?

Quels seront les nouveaux défis/enjeux ?

Sur une échelle de 1 à 5, comment qualifiez-vous le niveau d'adhésion des directeurs à cette vision de transformation ?

1 2 3 4 5

Adhésion faible — Adhésion totale

Quels sont les signes qui vous indiquent ce niveau d'adhésion ?

Votre implication dans le « COMMENT »

Sur une échelle de 1 à 5, comment qualifiez-vous le niveau d'implication des directeurs dans cette transformation ?

1 2 3 4 5

Implication faible — Implication maximale

Système de gestion intégrée de la performance

Comment est-ce que le concept de trajectoires s'intègre dans le système de gestion ?

Pour vous, un système de gestion intégré de la performance veut dire quoi ?

Quels apprentissages de SPCHUS ont été intégrés dans la transformation ?

Comment voyez-vous le déploiement du système de gestion de la performance ?

Schéma d'entrevue CIUSSS de l'Estrie — CHUS — janvier 2016

Objectif :

Comprendre la situation actuelle, les difficultés vécues par l'organisation, pour bien positionner la deuxième boucle d'apprentissage. Les sujets à couvrir inclus : Le positionnement/perception de la haute direction sur un système de gestion. Quelle est son importance dans l'organisation, et dans la culture organisationnelle ? Est-ce qu'on voit des changements dans la culture organisationnelle depuis le début de la fusion (symboles et significations) ? Quels sont les défies et les opportunités à amené un réel changement dans la façon de faire des choses dans le domaine de la santé ?

- Pour vous, quelle est la finalité souhaitée de la réforme ?
- Considérant la finalité souhaitée, comment qualifierez-vous le progrès fait à date au CIUSSS de l'Estrie — CHUS ?
- Considérant la vision, le principe d'action, les valeurs et la philosophie de gestion adoptés par le CIUSSS de l'Estrie, est-ce que les décisions et actions sont cohérentes ?
- Selon vous, quel est le niveau d'appropriation (adhésion et participation) des énoncés concernant le nouveau CIUSSS de l'Estrie — CHUS ?
- Pour vous, un système de gestion intégré veut dire quoi ?
- Quelle est la relation entre un système de gestion intégré et la culture organisationnelle, selon vous ?
- Quels ont été les évènements (internes/externes) qui auront peu influencé la culture organisationnelle depuis la fusion ?
- Quels sont les plus grands enjeux à la réussite de la fusion ?

Entrevues finales SGIP CIUSSS de l'Estrie-CHUS — Apprentissages du 2e cycle – automne 2017

Depuis les entrevues à la fin de la première boucle SPCHUS, des entrevues ont été faites avec tous les directeurs cliniques sur leur compréhension des trajectoires et SGIP (septembre 2015), et également avec les membres du comité de pilotage SGIP pour cibler le « readiness » de l'organisation de changer les façons de faire (mai 2016). De plus, un groupe de discussion a eu lieu en octobre 2016 pour cibler les apprentissages du déploiement de SGIP, et les résultats ont été présentés à la direction générale et au comité directeur et pilotage de SGIP.

Pour clôturer la collecte de donnée, des entrevues individuelles seront faites avec les membres du comité directeur, les membres du comité tactique, et les accompagnateurs. Les questions viseront à compléter les apprentissages sur l'intégration d'un système de gestion intégré de la performance, à voir s'il y a des évidences de changements dans les significations de certains symboles dans l'organisation et à comprendre la contribution de ma recherche pour l'organisation. Au total, 21 individus seront rencontrés.

Déroulement de l'entrevue (1 heure) :

Introduction (5 minutes) :

Je termine ma collecte de données pour ma thèse donc l'objectif est d'apprendre sur le processus de changement vécu par une organisation qui implante un système de gestion intégrée (ancré dans une philosophie Lean) et en quoi ceci constitue un changement culturel. L'entrevue va aider à faire ressortir vos impressions du processus, et ce que ça peut nous apprendre sur la culture organisationnelle et les efforts de changement culturel.

J'ai présenté au comité tactique un bilan détaillé de tous qui a été fait concernant SGIP depuis le mois d'avril 2015. J'ai également présenté une synthèse des apprentissages faits du Lean phase I, Lean phase II, SPCHUS et le bilan des RÉST. L'équipe a fait sortir plusieurs faits saillants (que je vais vous en parler dans l'entrevue) et est en train de préparer quelques recommandations. Suite aux entrevues, je vais compiler l'information pour vous présenter les thèmes, et les recommandations pour continuer avec le changement voulu.

Les questions sont regroupées en trois sections : 1) les évènements marquants, et les apprentissages du processus d'introduction d'un système de gestion intégré inspiré du Lean, 2) la signification/interprétation que vous donne de quelques événements/activités organisationnels et 3) la contribution de la recherche.

Avez-vous des questions ?

Questions sur les apprentissages et les ajustements requis (15 min) :

- Quelles ont été les décisions et actions marquantes dans la conception et le déploiement du SGIP au cours de la dernière année ?
- De quoi êtes-vous fier dans la transformation/introduction de SGIP ? Qu'est-ce qui vous désole, que vous regrettez où qui vous déçoit ?
- Si vous aviez à refaire la conception et l'introduction de SGIP, est-ce que vous feriez les choses autrement ?
- Quels apprentissages est-ce que l'organisation peut en tirer de la dernière année de travail sur le SGIP ?
- Considérant la finalité souhaitée, comment qualifierez-vous le progrès fait ?
- Quels sont les plus grands enjeux à la réussite du SGIP ?
- Étant donné les évènements marquants, les apprentissages et les enjeux, qu'est-ce que vous anticipez sur l'avenir de la transformation ?

Explication des questions sur la culture organisationnelle : Les questions qui seront posées sont inhabituel — ce n'est pas un langage qu'on est habitué à voir — on n'est pas dans les faits, mais dans l'interprétation/signification de certains éléments. Ceci est important, car je vois que l'organisation est une culture — les significations qu'on a des situations/événements/rituels/rencontres, etc. nous amènent à agir.
Je vais poser des questions sur des éléments jugés significatifs, pour vous demander comme vous les interprétez, ce qu'ils signifient pour vous.

Questions concernant la culture organisationnelle (30 min) :

- Comment décrierez-vous le fonctionnement de la salle de pilotage aujourd'hui en comparaison avec la première version (et pour ceux qui viennent du CHUS depuis la version CHUS) ?
    - À quoi sert-elle vraiment selon vous ? Pourquoi utilise-t-on cet outil ? En quoi la salle de pilotage constitue-t-elle un changement dans les pratiques de gestion ?
    - Quelle est la place de la salle dans la façon de gérer le CIUSSS de l'Estrie — CHUS ?
    - En quoi la salle de pilotage constitue-t-elle ou non un changement dans la façon de gérer le CIUSS ?
- En 2015, il y avait une gestion ambidextre pour gérer à la fois les projets et les opérations. Aujourd'hui, il n'y a pas de gestion ambidextre dans la salle de pilotage. Qu'est-ce que ça veut dire pour l'organisation ?
- Quelle est votre opinion sur les rencontres statutaires/de direction, leur intention, utilité ?
    - Qu'essaie-t-on d'accomplir à l'aide de ces rencontres ? Y parvient-on ?
    - Comment interprétez-vous le rôle de votre supérieur dans les rencontres ?
    - En quoi ce type de rencontre est-il une illustration ou une manifestation de la culture du CIUSSSE-CHUS ?

- Quelle est l'intention des rencontres de la direction générale ; plus spécifiquement la CCI, le forum des cadres supérieurs, le forum des gestionnaires ?
    - Est-ce que leur fonctionnement au moment présent répond à l'intention ?
    - Comment interprétez-vous cet écart (s'il y en a) ?
- Quelle est la signification de faire la planification annuelle avec un exercice de Hoshin Kanri en comparaison avec la manière dont la planification se faisait antérieurement ?

- Je vais énumères quelques événements, notés dans le bilan de la dernière année, et je vais vous demandez de me dire comment vous interprétez l'évènement et ce que ça vous dit sur l'organisation.
    - Il y avait une structure informelle qui s'est mise en place au tour de Noël 2015 pour intégrer et cadencer les priorités de transformation. Le travail de ce groupe a été arrêté à la fin février, suite à une rencontre de bureau de direction (élargi).
    - Des questions presque identiques sur la compréhension et les changements de comportements requis de SGIP ont été posées lors de deux forums des cadres supérieurs consécutifs (en mai et en septembre).
    - Dans le discours on entend régulièrement que l'usager, la population doit être au cœur des préoccupations (c'est le centre du vrai nord, c'est un élément important dans SGIP), comment cela se traduit-ils dans les objectifs vous mettez en place dans l'organisation.
        - Qu'est-ce que vous pensez du A3 comme outil pour mettre le patient au cœur de votre préoccupation ?
    - Pendant qu'une équipe travaillait à compléter le A3 sur le système de gestion intégrée de performance, un autre groupe travaillait à développer un modèle d'évaluation de la performance, M. Rondeau donnait des formations sur les trajectoires, la salle de pilotage se mettait en place, et les priorités organisationnelles ont été identifiées et ont été travaillées via des A3.
    - Le SGIP a été travaillé presque exclusivement par le DAEPO (direction adjointe de la performance). L'enjeu de son positionnement à un niveau tactique versus stratégique a été nommé au début de l'automne 2015. La première discussion avec le bureau de direction élargi au tour de SGIP a été le 31 mars 2016.
- Pouvez-vous représenter la façon dont vous voyez la transformation du CIUSSS de l'Estrie-CHUS par une image, un dessin ou un mot, une expression ? (si difficile, avez-vous déjà entendu des images que d'autres ont utilisées)
- Qu'est-ce qui selon vous caractérise la culture du CIUSS aujourd'hui
- Est-ce que les initiatives de changement entrepris au cours des deux dernières années constituent un changement dans la culture du CIUSS ? Est-ce qu'il y a

eu un changement de culture selon vous ? De quelle nature ? Est-ce que vous voyez votre organisation différemment aujourd'hui ? En quoi est-il différent ?
- De tous qu'on a discuté, quelles sont les 2 ou 3 affaires le plus percutantes concernant le changement de culture organisationnel ?

Merci beaucoup d'avoir répondu aux questions qui portent sur les interprétations et significations. Les dernières questions concernent la recherche qui a été réalisée au cours des dernières années.

<u>Questions concernant la contribution de ma recherche et clôture (10 min) :</u>
- Est-ce que la recherche a eu un effet quelconque (neutre, positif, négatif) sur le processus de développement/intégration de SGIP ? Sur quoi basez-vous pour dire ça ?
    - Est-ce que vous conseillerez ou non à d'autres d'utiliser la recherche-action pour l'intégration d'un système de gestion inspiré des principes Lean ?

Merci beaucoup ! Avez-vous des éléments que vous voulez ajouter que nous ne sommes pas couvert par les questions posées ?

APPENDIX E
CONSENT FORMS

FORMULAIRE D'INFORMATION ET DE CONSENTEMENT ENTREVUE

Titre du projet :	Déploiement du système de performance du CHUS : une transformation culturelle
Numéro du projet :	14-184/2014_15
Organisme subventionnaire :	Ministère de la santé et des services sociaux
Chercheur principal :	Mario Roy, Ph D, professeur à la faculté d'administration de l'Université de Sherbrooke et professeur titulaire de la chaire d'étude en organisation du travail (mario.roy @usherbrooke.ca).
Collaboratrice :	Joanne Roberts, MScA, doctorante en administration des affaires (joanne.roberts@usherbrooke.ca)..

Vous êtes invité(e) à participer à un projet de recherche. Le présent document vous renseigne sur les modalités de ce projet de recherche. S'il y a des mots ou des paragraphes que vous ne comprenez pas, n'hésitez pas à poser des questions. Pour participer à ce projet de recherche, vous devrez signer le consentement à la fin de ce document et nous vous en remettrons une copie signée et datée.

Objectifs du projet

La finalité du projet de transformation du CHUS prend l'allure suivante : « De façon transversale à travers toutes les directions, améliorer les trajectoires-patients par des processus efficients, de ressources utilisées judicieusement, des personnes engagées envers leurs pratiques et de soins et services accessibles et de qualité pour les patients. » Cette amélioration est sensée se traduire par une plus grande mobilisation des personnels, des gestionnaires et des médecins envers les patients et leurs familles.
L'objet de la recherche consiste à découvrir comment l'établissement se dotera d'une culture d'amélioration continue en l'accompagnant dans le déploiement de son système de gestion intégrée de performance.

Raison et nature de la participation

Votre participation à ce projet sera requise pour une entrevue d'environ une heure.
Les rencontres se tiendront à l'endroit qui convient le mieux aux membres de l'équipe, selon leurs disponibilités.
Vous aurez à répondre à des questions sur le projet de déploiement du système de performance au CHUS. Si vous êtes d'accord, cette entrevue sera enregistrée de façon

confidentielle sur une bande audio à laquelle seuls les responsables de la recherche auront accès.

J'accepte que l'entrevue soit enregistrée.
Oui ❒ Non ❒

Avantages pouvant découler de la participation

Votre participation à ce projet de recherche vous apportera l'avantage de participer à une recherche-action qui affectera le déploiement du système de gestion intégrée de performance au CHUS. Votre participation contribuera aussi à l'avancement des connaissances concernant l'adoption d'une culture d'amélioration continue et sa pérennisation au sein de votre établissement.

Inconvénients et risques pouvant découler de la participation

Dans la recherche-action, on considère que vous jouez un rôle de co-intervenant en participant au choix et à la mise en œuvre des changements. Votre participation à la recherche ne devrait pas changer votre travail quotidien ni comporter d'inconvénients significatifs, si ce n'est le fait de donner de votre temps. Vous pourrez demander de prendre une pause ou de poursuivre l'entrevue à un autre moment qui vous conviendra.

Droit de retrait sans préjudice de la participation

Il est entendu que votre participation à ce projet de recherche est tout à fait volontaire et que vous restez libre, à tout moment, de mettre fin à votre participation sans avoir à motiver votre décision ni à subir de préjudice de quelque nature que ce soit.

Arrêt du projet de recherche

Le chercheur responsable de l'étude, l'organisme subventionnaire et le Comité d'éthique de la recherche en santé chez l'humain du CHUS peuvent mettre fin à votre participation, sans votre consentement, s'il existe des raisons administratives d'abandonner l'étude.

Confidentialité, partage, surveillance et publications

Durant votre participation à ce projet de recherche, la personne responsable du projet recueillera et consignera dans un dossier de recherche les renseignements vous concernant. Seuls les renseignements nécessaires à la bonne conduite du projet de recherche seront recueillis. Ils peuvent comprendre les informations suivantes : nom, sexe, titre d'emploi, et ancienneté.

Tous les renseignements recueillis au cours du projet de recherche demeureront strictement confidentiels dans les limites prévues par la loi. Afin de préserver votre identité et la confidentialité de ces renseignements, vous ne serez identifié(e) que par un numéro de code. La clé du code reliant votre nom à votre dossier de recherche sera conservée par la personne responsable du projet de recherche.

La personne responsable de l'étude utilisera les données à des fins de recherche dans le but de répondre aux objectifs scientifiques du projet de recherche décrits dans ce formulaire d'information et de consentement.

Les données du projet de recherche pourront être publiées dans des revues scientifiques ou partagées avec d'autres personnes lors de discussions scientifiques. Aucune publication ou communication scientifique ne renfermera d'information permettant de vous identifier. Dans le cas contraire, votre permission vous sera demandée au préalable.

Les données recueillies seront conservées, sous clé. Les données seront détruites après publication d'un article dans une revue savante à déterminer. Les données seront détruites au plus tard 5 ans après la fin de l'étude. Aucun renseignement permettant d'identifier les personnes qui ont participé à l'étude n'apparaîtra dans aucune documentation.

À des fins de surveillance et de contrôle, votre dossier de recherche pourrait être consulté par une personne mandatée par le Comité d'éthique de la recherche Lettres et sciences humaines, ou par des organismes gouvernementaux mandatés par la loi. Toutes ces personnes et ces organismes adhèrent à une politique de confidentialité.

Résultats de la recherche et publication

Vous serez informé des résultats de la recherche et des publications qui en découleront, le cas échéant. Le chef de programme SPCHUS sera informé et aura la responsabilité de vous en informer. Nous préserverons l'anonymat des personnes ayant participé à l'étude.

Surveillance des aspects éthiques et identification du président du Comité d'éthique de la recherche Lettres et sciences humaines

Le Comité d'éthique de la recherche Lettres et sciences humaines a approuvé ce projet de recherche et en assure le suivi. De plus, il approuvera au préalable toute révision et toute modification apportée au formulaire d'information et de consentement, ainsi qu'au protocole de recherche.

1. Vous pouvez parler de tout problème éthique concernant les conditions dans lesquelles se déroule votre participation à ce projet avec la responsable du projet ou expliquer vos préoccupations à M. Olivier Laverdière, président du Comité d'éthique de la recherche Lettres et sciences humaines, en communiquant par l'intermédiaire de son secrétariat au numéro suivant : 819 821-8000 poste 62644, ou par courriel à : cer_lsh@USherbrooke.ca.

Consentement libre et éclairé

Je, _____ (*nom en caractères d'imprimerie)*, déclare avoir lu et/ou compris le présent formulaire et j'en ai reçu un exemplaire. Je comprends la nature et le motif de ma participation au projet. J'ai eu l'occasion de poser des questions auxquelles on a répondu, à ma satisfaction.
Par la présente, j'accepte librement de participer au projet.

Signature de la participante ou du participant : _____

Fait à _____, le _____ 201___

Déclaration de responsabilité des chercheurs de l'étude

Je, _____ collaboratrice de l'étude, me déclare responsable du déroulement du présent projet de recherche. Je m'engage à respecter les obligations énoncées dans ce document et également à vous informer de tout élément qui serait susceptible de modifier la nature de votre consentement.

Signature de la collaboratrice de l'étude : _____

FORMULAIRE D'INFORMATION ET DE CONSENTEMENT
GROUPE DE DISCUSSION

Titre du projet :	Déploiement du système de performance du CHUS : une transformation culturelle
Numéro du projet :	14-184/2014_15
Organisme subventionnaire :	Ministère de la santé et des services sociaux
Chercheur principal :	Mario Roy, Ph D, professeur à la faculté d'administration de l'Université de Sherbrooke et professeur titulaire de la chaire d'étude en organisation du travail (mario.roy @usherbrooke.ca).
Collaboratrice :	Joanne Roberts, MScA, doctorante en administration des affaires (joanne.roberts@usherbrooke.ca).

Vous êtes invité(e) à participer à un projet de recherche. Le présent document vous renseigne sur les modalités de ce projet de recherche. S'il y a des mots ou des paragraphes que vous ne comprenez pas, n'hésitez pas à poser des questions. Pour participer à ce projet de recherche, vous devrez signer le consentement à la fin de ce document et nous vous en remettrons une copie signée et datée.

Objectifs du projet

La finalité du projet de transformation du CHUS prend l'allure suivante : « De façon transversale à travers toutes les directions, améliorer les trajectoires-patients par des processus efficients, de ressources utilisées judicieusement, des personnes engagées envers leurs pratiques et de soins et services accessibles et de qualité pour les patients. » Cette amélioration est sensée se traduire par une plus grande mobilisation des personnels, des gestionnaires et des médecins envers les patients et leurs familles.

L'objet de la recherche consiste à découvrir comment l'établissement se dotera d'une culture d'amélioration continue en l'accompagnant dans le déploiement de son système de gestion intégrée de performance.

Raison et nature de la participation

Votre participation sera requise aux séances de travail du projet recherche-action concernant le déploiement du système de performance du CHUS. Les rencontres se tiendront à l'endroit qui convient le mieux aux membres de l'équipe, selon leurs disponibilités.

Vous aurez à participer aux discussions concernant le projet de déploiement, les changements visés et les actions à prendre. Si vous êtes d'accord, les discussions seront enregistrées et conservées de façon confidentielle sur une bande audio à laquelle seuls les responsables de la recherche auront accès.

J'accepte que l'entrevue soit enregistrée.
Oui ❒ Non ❒

Avantages pouvant découler de la participation

Votre participation à ce projet de recherche vous apportera l'avantage de participer à une recherche-action qui affectera le déploiement du système de gestion intégrée de performance au CHUS. Votre participation contribuera aussi à l'avancement des connaissances concernant l'adoption d'une culture d'amélioration continue et sa pérennisation au sein de votre établissement.

Inconvénients et risques pouvant découler de la participation

Dans la recherche-action, on considère que vous jouez un rôle de co-intervenant en participant au choix et à la mise en œuvre des changements. Votre participation à la recherche ne devrait pas changer votre travail quotidien ni comporter d'inconvénients significatifs, si ce n'est le fait de donner de votre temps. Vous pourrez demander de prendre une pause ou de poursuivre l'entrevue à un autre moment qui vous conviendra.

Droit de retrait sans préjudice de la participation

Il est entendu que votre participation à ce projet de recherche est tout à fait volontaire et que vous restez libre, à tout moment, de mettre fin à votre participation sans avoir à motiver votre décision ni à subir de préjudice de quelque nature que ce soit.

Cependant, étant donné qu'il s'agit de groupe de discussion il sera impossible d'effectuer une destruction totale des enregistrements. Les dialogues seront conservés pour garder la cohérence de la discussion. Par contre, les informations partagées par vous ne seront pas utilisées dans le projet de recherche.

Arrêt du projet de recherche

Le chercheur responsable de l'étude, l'organisme subventionnaire et le Comité d'éthique de la recherche en santé chez l'humain du CHUS peuvent mettre fin à votre participation, sans votre consentement, s'il existe des raisons administratives d'abandonner l'étude.

Confidentialité, partage, surveillance et publications

Durant votre participation à ce projet de recherche, la personne responsable du projet recueillera et consignera dans un dossier de recherche les renseignements vous concernant. Seuls les renseignements nécessaires à la bonne conduite du projet de recherche seront recueillis. Ils peuvent comprendre les informations suivantes : nom, sexe, titre d'emploi, et ancienneté.

Tous les renseignements recueillis au cours du projet de recherche demeureront strictement confidentiels dans les limites prévues par la loi. Afin de préserver votre identité et la confidentialité de ces renseignements, vous ne serez identifié(e) que par un numéro de code. La clé du code reliant votre nom à votre dossier de recherche sera conservée par la personne responsable du projet de recherche.

La personne responsable de l'étude utilisera les données à des fins de recherche dans le but de répondre aux objectifs scientifiques du projet de recherche décrits dans ce formulaire d'information et de consentement.

Les données du projet de recherche pourront être publiées dans des revues scientifiques ou partagées avec d'autres personnes lors de discussions scientifiques. Aucune publication ou communication scientifique ne renfermera d'information permettant de vous identifier. Dans le cas contraire, votre permission vous sera demandée au préalable.

Les données recueillies seront conservées, sous clé. Les données seront détruites après publication d'un article dans une revue savante à déterminer. Les données seront détruites au plus tard 5 ans après la fin de l'étude. Aucun renseignement permettant d'identifier les personnes qui ont participé à l'étude n'apparaîtra dans aucune documentation.

À des fins de surveillance et de contrôle, votre dossier de recherche pourrait être consulté par une personne mandatée par le Comité d'éthique de la recherche Lettres et sciences humaines, ou par des organismes gouvernementaux mandatés par la loi. Toutes ces personnes et ces organismes adhèrent à une politique de confidentialité.

Résultats de la recherche et publication

Vous serez informé des résultats de la recherche et des publications qui en découleront, le cas échéant. Le chef de programme SPCHUS sera informé et aura la responsabilité de vous en informer. Nous préserverons l'anonymat des personnes ayant participé à l'étude.

Surveillance des aspects éthiques et identification du président du Comité d'éthique de la recherche Lettres et sciences humaines

Le Comité d'éthique de la recherche Lettres et sciences humaines a approuvé ce projet de recherche et en assure le suivi. De plus, il approuvera au préalable toute révision et toute modification apportée au formulaire d'information et de consentement, ainsi qu'au protocole de recherche. Vous pouvez parler de tout problème éthique concernant les conditions dans lesquelles se déroule votre participation à ce projet avec la responsable du projet ou expliquer vos préoccupations à M. Olivier Laverdière, président du Comité d'éthique de la recherche Lettres et sciences humaines, en communiquant par l'intermédiaire de son secrétariat au numéro suivant : 819 821-8000 poste 62644, ou par courriel à : cer_lsh@USherbrooke.ca.

Consentement libre et éclairé

Je, _____ (*nom en caractères d'imprimerie)*, déclare avoir lu et/ou compris le présent formulaire et j'en ai reçu un exemplaire. Je comprends la nature et le motif de ma participation au projet. J'ai eu l'occasion de poser des questions auxquelles on a répondu, à ma satisfaction.
Par la présente, j'accepte librement de participer au projet.

Signature de la participante ou du participant : _____

Fait à _____, le _____ 201___

Déclaration de responsabilité des chercheurs de l'étude

Je, _____ collaboratrice de l'étude, me déclare responsable du déroulement du présent projet de recherche. Je m'engage à respecter les obligations énoncées dans ce document et également à vous informer de tout élément qui serait susceptible de modifier la nature de votre consentement.

Signature de la collaboratrice de l'étude : _____

APPENDIX F
IDENTITY STATEMENT CIUSSS DE L'ESTRIE— CHUS

La vision du réseau de la santé et des services sociaux

Des soins de santé et des services sociaux accessibles et efficients, qui s'adaptent aux besoins des Québécois.

Notre stratégie

EN ESTRIE, **ENSEMBLE,** INNOVONS POUR LA **VIE**

ESTRIE représente le territoire redécoupé en fonction du projet de loi n° 10, de même que les structures et les groupes qui s'y retrouvent.

ENSEMBLE inclut autant les employés, les bénévoles, les usagers et leur entourage, les médecins et les partenaires de la communauté. Implicitement, qui dit « ensemble » dit écoute, ouverture, partage et influence multidirectionnelle...

INNOVONS est un verbe d'action qui inspire un mouvement, une direction. Ce terme précise l'intention derrière le fait de réunir ces entités et ces personnes. Être innovant, c'est faire preuve de leadership, être inspirant, mobilisant, efficace, efficient, donc être performant.

POUR LA VIE fait référence au domaine dans lequel nous oeuvrons, soit la santé et les services sociaux, mais aussi à la santé et au bien-être de la personne dans sa globalité. Il est surtout question de la distinction de notre CIUSSS qui offre la presque totalité des soins et services offerts dans le réseau de la santé : de la prévention à la conception, jusqu'au décès.

L'ensemble parle de l'aspiration de chaque personne à participer, à contribuer à redéfinir la dynamique dans une perspective d'amélioration continue.

Notre principe d'action

LA COHÉRENCE

Avant toute chose : la cohérence *(Walk the talk)*.

LA COHÉRENCE est un ensemble d'idées ou de propositions qui constituent un tout logique, sans contradiction, permettant de trouver un sens commun à une décision ou à une action. Une parfaite cohérence mène à la compréhension, à l'acceptation, à la confiance et à l'adhésion et, par le fait même, il en découle une forme de continuité et de prévisibilité rassurantes pour la collectivité. Être cohérent, c'est être constant, fidèle à ses principes et savoir évoluer dans le temps en respect de ses fondements. De façon plus commune, on peut dire que les bottines doivent suivre les babines!

Ainsi, la cohérence est le principe d'action qui doit nous guider dans les décisions et les actions à l'égard des personnes recevant des soins et des services, de leur entourage, des membres du personnel, des médecins, des instances participatives, de la population et des partenaires.

Nos valeurs

Pour soutenir la nécessité d'être innovant : **L'ADAPTABILITÉ**

Pour soutenir la nécessité de travailler ensemble : **L'ENGAGEMENT**

Pour soutenir la nécessité d'accompagner toutes les personnes dans leurs réalités à travers tout le continuum de soins : **L'HUMANISME**

Centre intégré universitaire de santé et de services sociaux de l'Estrie – Centre hospitalier universitaire de Sherbrooke
Québec

Notre philosophie de gestion

1. **Gestion à l'écoute des besoins des personnes, au service de la population et qui s'ajuste rapidement**
   - En collaboration avec les proches aidants, les usagers et les partenaires socio-économiques
   - Responsabilité populationnelle
2. **Gestion axée sur le développement d'un leadership transformationnel des gestionnaires**
   - Capacité d'engager les autres
   - Coaching, atteinte des résultats, mobilisation, innovation
3. **Gestion misant sur la force de l'équipe**
   - Cogestion clinico-administrative, collaboration interprofessionnelle, stimulation par la relève et les stagiaires, «patient partenaire»
4. **Gestion participative qui encourage la responsabilisation et l'imputabilité**
   - Prise de décision décentralisée sur le terrain *(bottom up)*
   - Favorise une culture sans blâme
5. **Gestion valorisant le respect, le professionnalisme et la communication**
   - Dans la dispensation des soins et services
   - Dans les relations interpersonnelles
6. **Gestion soutenant la culture de la mesure, de l'évaluation et de l'amélioration continue en s'appuyant et en reconnaissant la mission universitaire comme partie intégrante de sa mission**
   - Avec nos partenaires universitaires
   - L'Unité d'évaluation des technologies et des modes d'intervention en santé, centres de recherche
   - Lean
   - Audit encouragé

PRINCIPES GÉNÉRAUX

1. **Adhérer à un modèle de performance reconnu**
2. **Bâtir sur les acquis des réseaux locaux et sur les réalisations des équipes à partager dans le CIUSSS**
3. **Regrouper la gestion des opérations dans le but de mieux les optimiser et les soutenir en tenant compte des bassins de desserte naturels des personnes**
4. **Impliquer l'usager, le personnel et les médecins dans l'amélioration et l'organisation des soins et des services**
5. **Favoriser la réalisation de la valeur sur le terrain**
6. **Partager l'expertise et miser sur l'engagement**
7. **Placer les six volets de la mission universitaire au cœur des actions (recherche, enseignement, pratique de pointe, évaluation des technologies et des modes d'intervention, transfert des connaissances et rayonnement)**